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ABSTRACT

This booklet presents the 3-year plan for Minnesota's management of developmental disabilities services and related issues for the period between October 1986 and September 1989. Section 1 presents definitions of developmental disabilities; estimates of general incidence; and effects on individuals, families, and communities. Section 2 describes the Governor's Planning Council on Developmental Disabilities and its members. Section 3 describes staff members providing assistance to the Council. Section 4 examines the state context of service issues, including the scope of services currently available, the Council's major concerns for the 3-year period, and the selection and administration of priority service areas. Section 5 outlines goals, objectives, and funding as well as application procedures for subgrantees under the Developmental Disabilities Basic State Grant Program. Section 6 presents pertinent assurances; and section 7 contains a summary of testimony from public hearings, bibliographic information on Council publications, a list of policy analysis papers relating to the Welsch consent decree, and a list of studies and reports relating to state schools for blind and/or deaf students. (21 references) (PB)

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STATE OF MINNESOTA

DEVELOPMENTAL DISABILITIES

10/1/86—9/30/89

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THREE-YEAR

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DEVELOPMENTAL DISABILITIES
THREE-YEAR STATE PLAN

October 1, 1986 – September 30, 1989

STATE OF MINNESOTA

Submitted by
The Minnesota Governor's Planning Council
on Developmental Disabilities

This State Plan is a joint endeavor of the Governor's Planning Council on Developmental Disabilities and Minnesota State Planning Agency.

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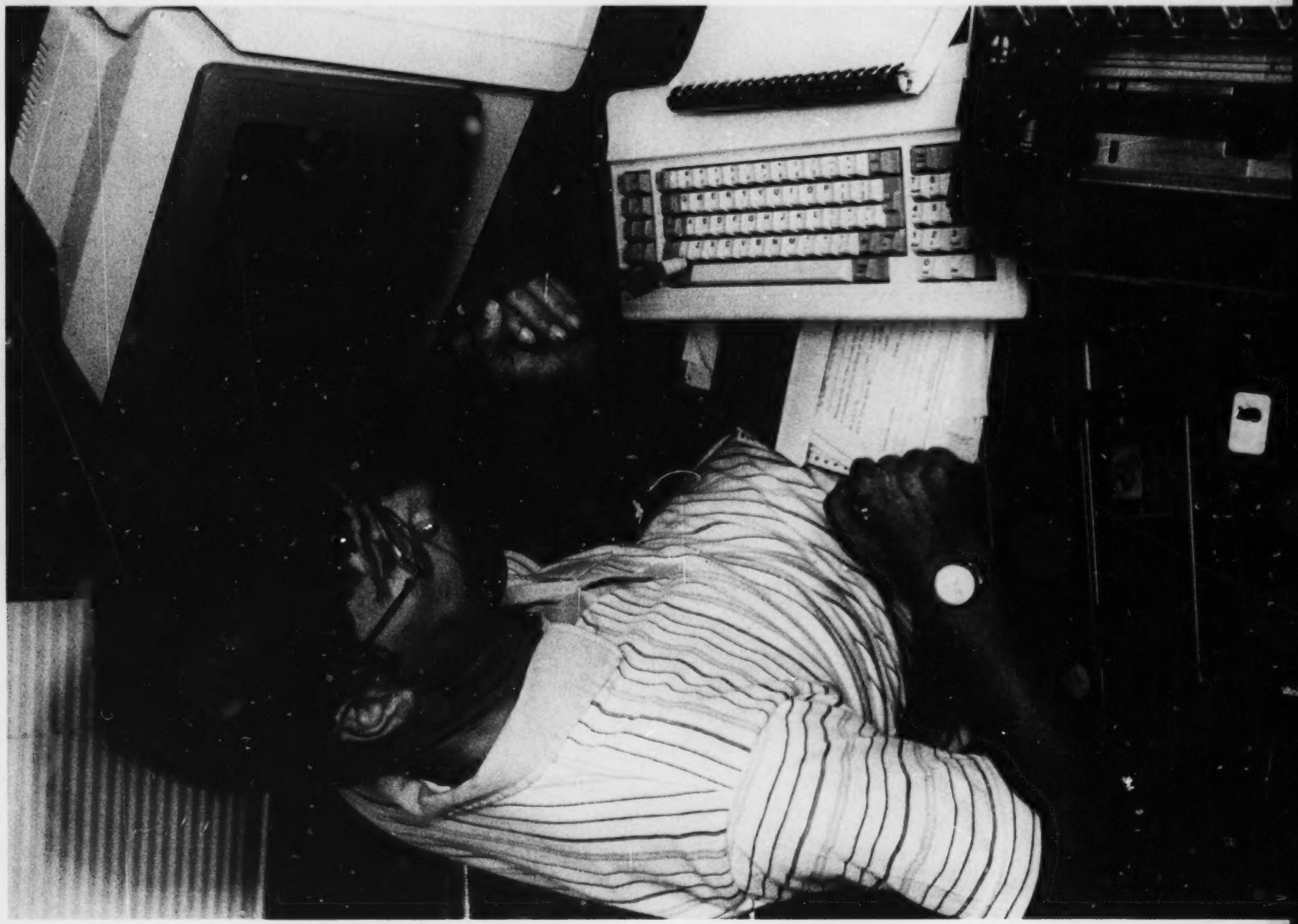

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SECTION 1:

Developmental Disabilities: Definition and Impact

1.1
What Are Developmental Disabilities?

Developmental disabilities are severe, chronic mental, and/or physical impairments which occur at an early age; are likely to continue indefinitely; and have a pervasive effect on an individual's functional abilities and need for services.

In Public Law (P.L.) 98-527, the Developmental Disabilities Assistance and Bill of Rights Act of 1984, Congress stated its findings as follows:

- There are more than two million persons with developmental disabilities in the United States;
- Individuals with disabilities occurring during their developmental period are more vulnerable and less able to reach an independent level of existence than other handicapped individuals who generally have had a normal developmental period on which to draw during the rehabilitation process;
- Persons with developmental disabilities often require specialized lifelong services to be provided by many agencies in a coordinated manner in order to meet the person's needs;
- Generic service agencies and agencies providing specialized services to persons with disabilities tend to overlook or exclude persons with developmental disabilities in their planning and delivery of services; and
- It is in the national interest to strengthen specific programs, especially programs that reduce or eliminate the need for institutional care, to meet the needs of persons with developmental disabilities. (Section 101(a))

1.1.1
The Federal Definition of Developmental Disabilities

Public Law 98-527 as amended, the Developmental Disabilities Assistance and Bill of Rights Act of 1984, defines a developmental disability as:

"a severe, chronic disability of a person which —

- is attributable to a mental or physical impairment or combination of mental and physical impairments;
- is manifested before the person attains age twenty-two;
- is likely to continue indefinitely;
- results in substantial functional limitations in three or more of the following areas of major life activity:
  self-care,
  receptive and expressive language,
  learning,
  mobility,
  self-direction,
  capacity for independent living, and
  economic self-sufficiency; and
- reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated." (Section 102(7))

1.1.2
Minnesota's Application of the Federal Definition

The Governor's Planning Council on Developmental Disabilities uses the federal definition in its Request for Proposal and requires grant recipients to meet that definition in implementing grants.

1.2
How Many People Have Developmental Disabilities?

A review of available estimates reveals that prevalence of developmental disabilities varies widely (Bruininks, Lakin, Hill, 1984, p. 22). Three population estimates may be used when calculating the possible number of people who may have a developmental disability:

Low: 1.0%
Estimate is based upon conservative projections mainly derived from various categorical studies.

Average: 1.6%
Estimate is based primarily upon studies using categorical definitions and various studies of institutionalized and noninstitutionalized persons, which is also close to the special report prepared by the Administration on Developmental Disabilities (ADD) on the impact resulting from the change in definition of developmental disabilities under P.L. 95-602, Section 202(6)(2) [ADD, May 1981].

High: 2.4%
Estimate is based primarily upon averages in recent analyses from State Developmental Disabilities Plans (p. 22).

1.3
How Do Developmental Disabilities Affect Individuals, Their Families, and Their Communities?

Over the past 20 years, both society's view of people who are disabled and the help offered to individuals and their families have changed. Minnesota statutes and court decisions document the changes and show a long history of concern for vulnerable people. New principles call for more normal and less "institutional" program settings, integration with nonhandicapped people, and citizen participation in decisions about their lives. These changes are the result of many events including the growing concern for individual rights, the effectiveness of advocacy groups, and the successes of people with disabilities in community programs. Community programs have grown to provide alternatives to placement in large state-operated facilities.

The mere **presence** of persons with disabilities in community settings has grown to mean a group home, a day program, paid staff, and limited integration opportunities. In contrast, **community participation,** as described by Kiracofe (1985), can mean a real home, a real job, a real friend, and a real community:

A 'real home' is choosing to live where you want, with whom you want, and for as long as you want . . . . A real home is an expression of the people who live there . . . . A 'real job' is paid work, an opportunity to be productive, and make a contribution. It leads to self worth . . . . A 'real friend' is a non-paid, non-professional companion, someone who chooses to spend time with you because they want to . . . . Relations that lead to friends, networks, and natural supports in the community are essential. The 'real community' is the natural community where all of us live, participate, and grow in . . . . The real community provides a sense of security in knowing that you belong. (pp. 6-7)

Using these estimates, the following figures would apply to the 1985 Minnesota population of 4,193,000:

ESTIMATE USED	ESTIMATED PERSONS WITH DEVELOPMENTAL DISABILITIES
Low (1.0%)	41,930
Average (1.6%)	67,088
High (2.4%)	100,632

The Minnesota Governor's Planning Council on Developmental Disabilities uses the 1.6 percent rate in estimating the population affected by developmental disabilities.

People with developmental disabilities live, learn, and work in Minnesota communities with support from special programs and generic or existing services used by everyone. For children who are developmentally disabled, the first choice for a home is with their own families. The help families need is varied, often short term, and far less costly than out-of-home care. In-home supports help keep families together.

Homes in the community should be family-sized, close to transportation and services, and provide individual attention to residents. In Minnesota, some adults with developmental disabilities live in their own homes or are in Semi-Independent Living Services (SILS) where they learn skills they need to care for themselves. A few hundred adults and children live with foster families. Over 5,000 people live in community Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). Residents of ICFs/MR must have a plan of care and 24-hour supervision.

Day programs for people with disabilities include preschool, special education for ages 3 to 21, and for adults, developmental achievement centers, work activity, sheltered work, supported employment or competitive employment. **(Developmental Disabilities and Public Policy: A Review for Policymakers,** January, 1983)

1.4
What Is the Developmental Disabilities Basic State Grant Program?

The Developmental Disabilities State Grant Program is a federally assisted State program designed to assure ". . . that persons with developmental disabilities receive the care, treatment, and other services necessary to enable them to achieve their maximum potential through a system which coordinates, monitors, plans, and evaluates those services . . . ." (Section 101(b)(1))

The specific purposes of the Basic Grant Program, as outlined in Section 101(b)(2) of Public Law 98-527, are as follows:

(A) to assist in the provision of comprehensive services to persons with developmental disabilities, with priority to those persons whose needs cannot be covered or otherwise met under the Education for All Handicapped Children Act, the Rehabilitation Act of 1973, or other health, education, or welfare programs;
(B) to assist States in appropriate planning activities; and
(C) to make grants to States and public and private, non-profit agencies to establish model programs, to demonstrate innovative habilitation techniques, and to train professional and paraprofessional personnel with respect to providing services to persons with developmental disabilities . . . .

The program works closely with the State Protection and Advocacy Agency ". . . to ensure the protection of the legal and human rights of persons with developmental disabilities." (Section 101(b)(1))

In Minnesota, the State Protection and Advocacy Agency is the Legal Aid Society of Minneapolis, Legal Advocacy for Developmentally Disabled Persons in Minnesota.

SECTION 2:

The Governor's Planning Council on Developmental Disabilities

2.1
What Is the Governor's Planning Council on Developmental Disabilities?

The Minnesota Governor's Planning Council on Developmental Disabilities is a planning body composed of 27 members including persons with developmental disabilities and their families. The Developmental Disabilities Act of 1984 requires each state Council to include in its membership representatives of the principal state agencies, especially those agencies responsible for administering federal funds under:

- The Rehabilitation Act of 1973 (i.e., the Division of Rehabilitation Services of the Minnesota Department of Jobs and Training);
- The Education of All Handicapped Act (i.e., Special Education Services of the Minnesota Department of Education); and
- Title XIX of the Social Security Act (i.e., the Minnesota Department of Human Services).

Standing representation also includes the Minnesota University Affiliated Program and Legal Advocacy for Developmentally Disabled Persons in Minnesota. Other representation comes from higher education training facilities, local agencies, nongovernmental agencies, and groups concerned with services to persons with developmental disabilities.

At least 50 percent of the Council membership must consist of persons with developmental disabilities or parents or guardians of such persons. Of that 50 percent, one-third must be persons with developmental disabilities and another one-third must be immediate relatives or guardians of persons with mentally impairing developmental disabilities. At least one individual must be an immediate relative or guardian of an institutionalized person with a developmental disability.

Members are appointed by the Governor for three-year terms with a maximum of two terms.

The Council is charged with supervising the development of a three-year state plan describing the quality, extent, and scope of needed services being provided or to be provided to persons with developmental disabilities; to monitor and evaluate the implementation of the state plan; and to review state services plans for persons with developmental disabilities. (Executive Order 83-16)

2.2
Who Are the Council Members?

Ms. Elaine Saline, Chair
Mr. Richard S. Amado, Ph.D.
Mr. Marcel A. Bourgeault
Mr. Doug Butler
Mr. Robert DeBoer
Mr. Roger A. Deneen
Ms. Suzanne M. Dotson
Ms. Sandra J. Fink, Ph.D.
Ms. Virginia Hanel
Ms. Anne L. Henry
Ms. Paula H. Johnson
Ms. Helmi Lammi
Ms. Margaret Lindstrom
Mr. Gerald Nelson
Mr. Bill Niederloh
Ms. Nancy Okinow
Ms. Dorothy Peters, Ed.D.
Ms. Barbara Pihlgren
Ms. Ruth Rafteseth
Ms. Jan Rubenstein
Mr. Glenn Samuelson
Ms. Sharon Shapiro
Mr. Ed Skarnulis, Ph.D.
Ms. Karen Titrud
Mr. Larry Wefring

The state provides assurance that federal membership requirements have been met.

SECTION 3:

The Administering Agency for the Developmental Disabilities Program

3.1
What Is the Designated State Administering Agency?

The designated state administering agency is the Minnesota State Planning Agency. The Developmental Disabilities Program, in the Human Services Division, is responsible for providing staff and other administrative assistance to the Governor's Planning Council on Developmental Disabilities.

3.2
Who Are the Staff Members?

The administering agency staff includes:

Colleen Wieck, Ph.D.
Executive Director. Ms. Wieck has a Doctor of Philosophy (Ph.D.) degree in educational psychology (special education). She has worked in the field of developmental disabilities for fourteen years, serving as executive director for the Minnesota Governor's Planning Council on Developmental Disabilities for the past five years.

Audrey Clasemann
Office Coordinator. Ms. Clasemann has an Associate of Arts (A.A.) degree in graphic arts and specialized training in format editing and report typing (technical/statistical typing). She has been employed by the state of Minnesota for over fourteen years and has been on the staff of the Governor's Planning Council on Developmental Disabilities for the past four years.

RoseAnn Faber
Human Services Planner. Ms. Faber has a Master's of Social Work (M.S.W.) degree and has worked with the Minnesota Governor's Planning Council on Developmental Disabilities for almost twelve years. She is primarily responsible for legislative activities and for reviewing and making comments on proposed policies.

Ron Kaliszewski
Grants Administrator. Mr. Kaliszewski has a Master's of Science (M.S.) degree in community planning and has worked for the State of Minnesota for twenty-two years. He has been employed with the Minnesota Governor's Planning Council on Developmental Disabilities for over five years.

Roger Strand
Human Services Planner. Mr. Strand has a Master's Degree in Social Work (M.S.W.) and has worked in the field of developmental disabilities for twenty-one years. He has served on the staff of the Governor's Planning Council on Developmental Disabilities for over fourteen years and is currently responsible for public information, training, and policy analysis.

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SECTION 4:

The State Context

4.1
What Is the Environment in Which the Developmental Disabilities Program Operates in Minnesota?

Several factors affect decision making regarding services for persons who are developmentally disabled in Minnesota. These factors include: (a) an increased capacity and use of information about the service system and policy development; (b) a number of changes in the human service system, such as the *Welsch* Consent Decree, the decentralization of responsibility for provision of social services by counties, and a number of legislative mandates such as the reduction of the number of beds in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR); (c) an increased concern about children and youth with developmental disabilities as they experience the transition from school to work and community living; and (d) the provision of opportunities for supported employment of people with developmental disabilities.

Availability and Utilization of Information:

The Minnesota Governor's Planning Council and its staff have played an important role in gathering information about the service system and providing policy analysis regarding issues that need attention by decision makers and concerned citizens, such as legislators, state and county administrators, providers of services, and consumers of services. The purpose of this activity has been to educate and inform people so that all can actively participate in shaping the future delivery of services and provisions for persons with developmental disabilities and their families. An annotated list of the publications of the Governor's Planning Council on Developmental Disabilities, State Planning Agency, is provided as an attachment in Section 7.2 of this plan.

Changes in the Human Service System:

Services for persons with mental retardation or related conditions have been described by officials at the Department of Human Services as "Minnesota's most dramatically changing social service system" (Minnesota Department of Human Services, 1985). In an instructional bulletin (#85-137, December 11, 1985), three consistent trends have been observed: (1) programmatic shifts, (2) new county responsibilities, and (3) new relationships between state and county governments as well as between counties and providers:

1. Programmatic shifts: This change has reflected a national trend away from bricks and mortar to a program of integrated community services. It is a shift toward the use of ordinary housing, generic services, and employment programs in the everyday work place. This change is reflected in the phrase, "People need specialized services, not specialized buildings."
2. County responsibilities: With the passage of the Community Social Services Act of 1979 and several other laws enacted since that time, the counties have been authorized greater responsibilities for managing programs and making major decisions on behalf of persons with mental retardation and related conditions and their families.
3. New Relationships: The Department of Human Services has adopted a very clear goal of establishing a state supervised, county administered system of mental retardation services that is integrated with the local system of social services (p. 2).

Some of the other changes in the human services delivery system are reflected in the following examples:

- ***Welsch* Consent Decree:** The *Welsch* Consent Decree was signed in U.S. District Court in September 1980. The Decree required the state of Minnesota to substantially reduce the overall populations of persons who are mentally retarded residing in state-operated, regional treatment centers by 1987. The prescribed rates of reduction have been achieved with each year; reducing these populations from 2,650 in 1980 to 2,029 in 1985. As of July 1, 1986, there were 1,846 people in the regional treatment centers. (This number includes provisional discharges.) Provisions of the Consent Decree also address the need for improved conditions in regional treatment centers and the development of services for persons with mental retardation who are discharged from regional treatment centers.

  A study conducted by the Program Evaluation Division of the Office of the Legislative Auditor (1986, February) concluded that although the Department of Human Services had successfully reduced the population within the regional treatment centers serving persons with mental retardation and had met the requirements under the *Welsch* Consent Decree regarding the staff-to-resident ratios, several issues were identified as being unresolved: (1) children continued to be admitted to regional treatment centers and were staying longer than the one-year limitation; (2) individual program plans were determined to be generally inadequate; (3) the use of restraints, seclusion, and medications to control residents' behavior had not been reduced at several of the centers; and (4) frequently, staff did not possess necessary skills to implement individual programs, particularly in the area of behavior management. The Legislative Auditor's report concluded that the Consent Decree had made a difference and that the Legislature should consider continuing outside monitoring of the regional treatment centers and the community residential facilities beyond July 1, 1987, when the Consent Decree is scheduled to end (p. xiv).

  The Governor's Planning Council on Developmental Disabilities has published several policy papers on the *Welsch* Consent Decree as well as having lead responsibility for a state legislatively mandated study of the entire state hospital system. All papers are described in Section 7.2. The future of regional centers is described in *Policy Paper No. 8* by four major options: (1) continue to downsize, (2) begin state-operated community services, (3) introduce elements of competition, and (4) closure. Each option is described in terms of its impact on residents, employees, community, and cost.

- **Reduction of ICFs/MR Beds:** Minnesota ranks third in the nation for having the greatest number of beds per capita in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) and for having among the highest expenditures for these programs (Legislative Audit Commission, 1983). In 1983, the Minnesota Legislature placed a moratorium on the construction of new beds in ICFs/MR, unless county boards could document a specific need for such a facility. The Legislature also required a reduction of the number of beds from 7,500 to 7,000 by July 1986. There is increased recognition on the part of providers of services to move toward smaller, more normal living situations.

- **Respite Care Policy:** The Department of Human Services issued a policy which restricts the provision of respite care services in regional treatment centers. Regional treatment centers had been one of the major providers of such relief services to caregivers in the past which had curtailed the development of respite care services in community settings, closest to where people live.

- **Waivered Services:** The "Home and Community Based Waiver" program provides an alternative way of using Title XIX (Medicaid) dollars to assist the state and counties in moving people from regional treatment centers, reducing the number of Intermediate Care Facility beds and developing new community services. Services which may be funded under this program include: case management, respite care, day habilitation, homemaker, in-home support, supported living for children and adults, and minor physical adaptations in dwellings. By October 1, 1986, there were 650 people being served under the waivered services program. Due to a cap of 1,000 participants placed by the Legislature on this program, it is anticipated that all of these positions will be used by the counties during the 1986-87 biennium.

- **Case Management Regulations:** The Department of Human Services has issued Rule 9525.0015 to 9525.0165 (referred to as Rule 185) that will directly place the responsibility for case management services at the county level. Decision making for services to individuals would rest with county case managers while fundamental control of the type and scope of services being offered by providers would remain with the county board.

- **Persons with Related Conditions:** The 1985 Legislature passed amendments to several statutes which made services available to people with "related conditions." These individuals now have access to services that have traditionally been designated only for persons with mental retardation. Proposed rules to provide services to this expanded population are being prepared by the Department of Human Services.

- **State-Operated Services:** A small number of waivered service positions have been reserved in order to pilot a state-operated program of services in community settings. These pilot programs would not only help move persons from regional treatment centers but would also offer a different form of employment opportunity for state employees of the regional treatment centers.

Transition Services and Supported Employment

The topics of transition and supported employment have received major national attention during the past three years. In Minnesota, this awareness is demonstrated by: (1) the establishment by the 1985 Legislature of an Office of Transition within the Department of Education which is to focus on the movement of students with disabilities from secondary schools into vocational training programs, supported employment, competitive employment or other community programs; and (2) receipt of a grant to create changes in the service delivery system in Minnesota to provide supported employment opportunities. This grant was awarded by the Office of Special Education and Rehabilitative Services (OSERS) of the U.S. Department of Education to the Division of Rehabilitation Services in the Department of Jobs and Training in conjunction with the Department of Education, the Department of Human Services, and the State Planning Agency.

4.1.1
Issues and Concerns Which Influence Services for People with Developmental Disabilities

The two long-range issues which the Council is addressing are: (a) community integration of all people with developmental disabilities, and (b) removal of fiscal disincentives which discourage placement in the least restrictive environment. The Council recognizes that Minnesota must continue to make major changes in the way services are provided if we are to fully accomplish the integration of all people with developmental disabilities. The Council is on record in support of the Community and Family Living Amendments. The Council has also adopted the following positions:

- Services should be provided at the local level so that persons with disabilities can be served in community-based programs regardless of the severity of their disability.
- Admissions and readmissions to institutions should be prevented.
- Persons with developmental disabilities should have access to generic resources and settings whenever those resources and settings are appropriate to meet individual needs.
- Communities should develop a full range of services to meet the developmental and human needs of persons with developmental disabilities.
- Support should be provided to families to assist them in meeting the needs of family members who are developmentally disabled, and individualized program plans should be used to develop the skills of persons with developmental disabilities so that they may participate in and contribute to their community. (Minnesota Governor's Planning Council on Developmental Disabilities, 1982)

The removal of fiscal disincentives and movement to the least restrictive environment have continued to be important issues as budget cutbacks have led to overall reductions in service dollars. The Council believes that it is possible to both contain costs and provide people with developmental disabilities with the opportunity to live, work, and learn in the least restrictive environment. However, current funding patterns in Minnesota favor the most expensive and most restrictive settings. Smaller, more homelike living arrangements in community settings frequently have unstable funding and draw upon a greater proportion of local dollars than do more restrictive options. The Council views the issue of fiscal disincentives as a critical one which must be addressed if persons with developmental disabilities are to receive the most appropriate and cost-effective services.

4.1.2
The Scope of Services for Persons with Developmental Disabilities

Services for persons with developmental disabilities are located in several agencies. The state plans developed by these agencies have been analyzed and a summary of common priorities is presented in Table 4.1.2.a. This table serves as a possible guide for future interagency coordination and cooperation.

The agencies are presented in the following order: (a) Department of Jobs and Training, Division of Rehabilitation Services (DRS); (b) Department of Human Services; (c) Minnesota Department of Health; (d) Minnesota Department of Education; (e) State Board of Vocational-Technical Education; (f) Legal Advocacy for Developmentally Disabled Persons in Minnesota; and (g) Minnesota University Affiliated Program on Developmental Disabilities.

TABLE 4.1.2.a

Summary of Minnesota State Plans
(Reviewed August 1985)

PRIORITY AREAS IDENTIFIED IN STATE PLANS	MINNESOTA STATE PROGRAM								
	Maternal and Child Health	Pre-School Incentive Grant	Special Education	Vocational Education	Developmental Disabilities/ Protection and Advocacy	State Council for the Handicapped	Governor's Planning Council on Developmental Disabilities	Division of Rehabilitation Services	Job Training Partnership Act
Early Intervention/Prevention:									
• Prenatal care/infant mortality	X								
• Consumer/parent/public information	X	X	X	X	X	X	X	X	
• Family planning	X								
• Family support services (e.g., respite care)	X	X				X	X		
• School health/mental health curriculum	X								
• Teenage pregnancies	X								
• Safety education	X			X					
• Environmental quality	X								
Employment/Habilitation:									
• Work preparation and placement				X		X	X	X	X
• Transition from school to work			X	X		X	X	X	X
• Increase employment opportunities						X	X	X	X
• Supported employment							X	X	
Community Living/Integration:									
• Independent living						X	X	X	
• Housing						X			
• Accessibility					X	X	X		
Quality and Quantity of Services:									
• Children and/or adolescents	X	X	X	X	X	X	X		
• Adults				X	X	X	X		
• Technological applications			X				X	X	
• Licensure/monitor quality			X		X				
Administrative Services:									
• Improve administrative efficiency			X	X	X		X		
• Interagency coordination	X	X	X	X	X	X	X	X	X
• Personnel training		X	X		X		X		
• Technical assistance		X			X		X		
• Policy reform (legislation/regulations)		X	X						
• Information systems/evaluation			X	X		X	X	X	
• Local comprehensive planning	X	X	X		X	X	X		
• Case management/guidance services				X				X	
Advocacy/Protection of Rights:									
• Protective services					X				
• Legal services					X				
• Affirmative action/employment discrimination						X			X

DEPARTMENT OF JOBS AND TRAINING, DIVISION OF REHABILITATION SERVICES (DRS)[1]

Agency Purpose: The purpose of the Department of Jobs and Training (DRS) is to develop, implement, and coordinate employment and income policies for the state of Minnesota. It is the state's principal agency for employment and job training, vocational rehabilitation, and the unemployment insurance program.

For those whose physical, mental, or emotional disabilities are a handicap to employment, the Department provides an array of services including training and placement in competitive employment or sheltered work. Additionally, the 1985 Legislature appropriated $2.4 million to DRS for the biennium to fund community-based employment services and establish an information system and salary for one person to monitor implementation of the new program.

The Rehabilitation Services Program provides services through 40 statewide offices. The primary objective of the Division of Rehabilitation Services is to prepare persons with physical, mental, and emotional disabilities to engage in gainful employment to the extent of their ability. Each person is assigned to a counselor and receives counseling and guidance based on a jointly developed individualized written rehabilitation plan. The Division has cooperative arrangements with public schools, regional treatment centers for persons who are mentally ill or mentally retarded, and state correctional institutions to help provide broader and more timely vocational rehabilitation services. The employment dimension has three aspects: providing placements in gainful employment, providing employment opportunities in sheltered workshops, and most recently creating community-based employment opportunities.

The Division of Rehabilitation Services has a second objective of training persons who are severely handicapped to live independently. These persons may not be able to become employed; but through special training and modification of a community living site, they gain a measure of independence and self-sufficiency. In 1985, Independent Living Centers were recognized in Minnesota Statutes. Provisions addressed broad structure, services offered, and procedures for certification and application for state funds. The 1985 Legislature also authorized two additional centers for independent living bringing the total to five in the state.

Clientele: In federal fiscal year 1985, 3,645 persons were placed in competitive employment, 550 persons were placed in sheltered employment, 142 persons were self-employed, 63 persons were rehabilitated to be homemakers/family workers for a total of 4,400 placements. In addition there were 2,597 persons with handicaps served through the three Centers for Independent Living.

State Services for the Blind:

Legislation passed during the 1985 Legislative session resulted in the transfer of State Services for the Blind from the Department of Human Services to the Department of Jobs and Training, Division of Rehabilitation Services. State Services for the Blind will remain a distinct unit with its own budget and seven-member advisory council. In federal fiscal year 1985, State Services for the Blind successfully rehabilitated 599 persons under the Rehabilitation Services Program. An additional 632 persons were successfully served under the self-care/independent living program.

[1]Formerly the Department of Economic Security, Division of Vocational Rehabilitation.

Supported Employment Grant from OSERS:

In October 1985, the state of Minnesota received a grant from the United States Department of Education, Office of Special Education and Rehabilitative Services (OSERS). The Division of Rehabilitation Services (DRS) of the Department of Jobs and Training is the host agency for this grant. Cosponsoring agencies include: the Department of Human Services, the Department of Education, and the Developmental Disabilities Council of the State Planning Agency. The purpose of the OSERS grant is to increase the quantity and quality of paid integrated work opportunities for persons with severe disabilities and to improve their quality of life as measured by integration and productivity.

The objectives of the Supported Employment Project have been designed to create major system change as stated below:

- Foster state and local leadership within the consumer, advocacy, and parent community and the general public to build broad consensus for integrated paid work opportunities for persons with severe disabilities;
- Develop and deliver training and outside technical assistance to support new and existing local supported employment programs to ensure an adequate statewide supply of qualified personnel;
- Foster effective case management so that supported employment addresses individual needs;
- Foster state and local leadership for supported employment initiatives within the business community by developing closer working relationships and incentives for increased employer participation in order to ensure an adequate supply of paid work opportunities;
- Restructure the funding base of supported employment programs so that it is equitable for all clients, providers, and regions of the state. Redirect existing funding for segregated settings to integrated ones, develop new funding streams, and create a long-term state source of funds so that a full range of opportunities is achieved and sustained beyond the grant period; and
- Amend state statutes to include definitions of supported employment.

Division of Rehabilitation Services State Plan: This plan allows the agency to check those services which are available. Services available to individuals include:

- Evaluation of rehabilitation potential;
- Counseling guidance and referral;
- Physical and mental restoration services;
- Vocational and other training services;
- Services to members of handicapped individual's family necessary to the adjustment of the individual with a handicap;
- Interpreter services for people who are deaf;
- Telecommunications, sensory, and other technical aids and devices;
- Recruitment and training services to provide new employment opportunities;
- Listing of suitable employment;
- Provide employment services needed to obtain appropriate employment; and
- Occupational licenses, tools, equipment, stocks, and supplies necessary to begin a particular occupation as well as other goods and services to enhance an individual person's employability.

The program provides for the establishment and construction of nonprofit rehabilitation facilities. Information and referral services are available to all clients. Cooperative arrangements exist between the Division of Rehabilitation Services and school districts to provide services to eligible students within schools.

Job Training Partnership Act (JTPA):

In Minnesota, the Job Training Partnership Act (JTPA) is administered by the State Job Training Office, a division within the Department of Jobs and Training. This office provides staff support to the Governor's Job Training Council which is responsible for making recommendations to the Governor on policies, coordination of services, and the implementation of a state's plan.

The purpose of the Job Training Partnership Act is to establish programs to prepare youth and unskilled adults for entry into the labor force. Job training is provided to individuals who are economically disadvantaged and others who face serious barriers to employment.

There are sixteen Service Delivery Areas in Minnesota which plan and provide services according to locally defined needs and priorities. Within each of these local areas is a Private Industry Council. It is the role of these Councils together with the local elected officials to determine what services will be provided, what agency or agencies will manage and operate the programs, and what populations will be targeted for services.

Between July 1, 1985, and March 31, 1986 (nine months), 27,639 people in Minnesota were served through the JTPA program. Of that number, 2,975 people (10.7 percent) had handicapping conditions.

DEPARTMENT OF HUMAN SERVICES

Social Services:

Program Purpose: The role of the Department of Human Services (DHS) is broad and comprehensive. Responsibilities of its various divisions include setting policies and promulgating rules based on statutes that provide needed services to a diverse population such as: persons with chronic mental illness (30,000 estimated being served), mental retardation or related conditions (13,000 estimated being served), or severe hearing and visual impairments. This is accomplished through: (1) management of community residential treatment centers and support services provided by county and community mental health centers (Mental Health Program Division — DHS); and (2) the administration of a myriad of services authorized by counties which include home and community-based (waivered services), Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR), semi-independent living, adult and child foster care, family subsidy, and training and habilitation services (Mental Retardation Program Division — DHS); and (3) direct and indirect delivery of services and technical assistance at regional service centers to make available and accessible a full range of programs to persons who are deaf or hearing impaired (Services for the Deaf — DHS). The Department also directly provides services to individuals in eight regional treatment centers and two state nursing homes.

Income Maintenance:

The Department of Human Services provides income maintenance through cash assistance, food stamps and payments to providers of medical and health care services to and on behalf of needy citizens of the state. These cash assistance and medical payments exist to provide a basic standard of living and enable low income citizens to have access to quality medical care for both acute and chronic health needs. Through this assistance, persons with low income have access to the basic necessities — food, clothing, shelter, and medical care — required by all persons. In addition, the department carries out management control functions with regard to Aid to Families with Dependent Children (AFDC), food stamps, and medical assistance. This Division reviews local agency management of the food stamp program and gathers necessary data to claim federal funds and complete a wide range of internal management reports.

Local agency staff determine individual eligibility for all programs, make cash assistance payments, and issue food stamps. The major goal of the Income Maintenance Program is to provide appropriate cash assistance, noncash assistance benefits, or medical benefits so that all eligible citizens are served in an effective and efficient manner.

The number of people requiring assistance and the cost of programs change in relation to demographic change as well as change in national, state, and local economic conditions.

Operation: Department staff provide program guidelines to local agencies in the form of rules and policies which are designed to maximize the use of federal funding while ensuring the needs of low income persons are met. In addition, state agency staff make payments to providers of medical and health services, conduct postpayment audits to detect abuse and/or fraud by recipients or providers of the medical assistance program and recipients of cash assistance and food stamp programs.

Services for Persons Who Are Chemically Dependent, Mentally Ill, or Mentally Retarded:

Program Purpose: The Department of Human Services provides extensive services to persons who are chemically dependent, mentally ill, or mentally retarded or have related conditions to assure that they receive humane care and appropriate treatment at the most effective and accessible level to enable them to live as productively and independently as possible.

The Department works to promote prevention of these disabilities, to identify needed services, and to aid in the development of programs by local agencies. The Department works to develop state plans, coordinates the delivery of services among state and local agencies, develops service standards for each disability, provides technical assistance to counties and service providers, administers certain categorical and federal block grant programs, monitors county and provider compliance with standards, promotes prevention services, and evaluates the effectiveness of services. The Department supervises the operation of eight regional treatment centers and two state nursing homes.

Tables 4.1.2.b, c, and d describe the number of persons served and their characteristics, expenditures for services, and average cost per person by service category.

Three services for persons with mental retardation and related conditions have been selected and described:

Related Conditions: As a result of efforts by a coalition composed of a number of consumer organizations, Legal Advocacy for Developmentally Disabled Persons in Minnesota, and the Developmental Disabilities Council, the 1985 Legislature passed a bill which updated many obsolete references to persons with mental retardation and mental illness. This bill also makes persons with "related conditions" eligible for services previously provided only to persons who are mentally retarded. Such services include those of the Developmental Achievement Centers, Intermediate Care Facilities for the Mentally Retarded, and Title XIX Waivered Services. "Related conditions" is defined as:

A person has a "related condition" if that person has a severe, chronic disability that is (a) attributable to cerebral palsy, epilepsy, autism, or any other condition, other than mental illness, found to be closely related to mental retardation because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation or requires treatment or services similar to those required for persons with mental retardation; (b) is likely to continue indefinitely; and (c) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, or capacity for independent living. (MINN. STAT. Chapter 252.27, Subd. 1)

Family Subsidy: The Family Subsidy Program provides a monthly stipend of up to $250 to families with a child who is mentally retarded or has a related condition to enable that child to remain at home delaying or avoiding placement in a community-based ICF/MR or regional treatment center. Applications are taken by county social service agencies with approval and funding completed by the Department of Human Services. Stipends may be used to purchase special equipment, food, or clothing needed by the child as well as respite care, baby-sitting, or transportation. Results of a survey of parents who use the program, reported in *Welsch vs. Levine Policy Analysis Series Paper No. 18*, show that parents find the program extremely beneficial. Presently, 250 families are served by the program with a waiting list of 130 families.

Semi-Independent Living Services (SILS): This program serves persons who do not need 24-hour supervision. The program provides training in the skills necessary for a person who is mentally retarded to live independently, including such skills as household management, personal grooming and hygiene, and use of public services. Presently, there are 880 persons served, and there is a waiting list of 640 persons for this program.

TABLE 4.1.2.b

Services to Persons with Mental Retardation in Minnesota: Number of Persons Served and Characteristics by Type of Service — 1982 through 1985

	Number of Persons Served by Service Category				Percentage of Persons Served in Service Categories by Age Group, Sex, and Level of Function								
	Number of Persons Served				Age Group		Sex		Level of Function				
Service Category	SFY 1982	SFY 1983	SFY 1984	SFY 1985	Birth to 21	21 and Over	Male	Female	Profound	Severe	Moderate	Mild	Other
State Hospitals	2,536	2,440	2,225	2,291	8%	92%	59%	41%	62%	22%	8%	6%	2%
ICFs-MR (Community)	5,168	5,645	5,631	5,764	23%	77%	55%	45%	28%	22%	22%	26%	2%
Developmental Achievement Centers	5,399	5,815	6,105		27%	73%	—	—	9%	25%	25%	15%	26%
Semi-Independent Living	458	698	1,019	1,050	4%	96%	—	—	0%	2%	18%	49%	31%
Waivered Services	—	—	—	308	34%	66%	46%	54%	15%	19%	24%	32%	10%
Family Subsidy	156	195	200	229	100%	0%	56%	44%	32%	41%	14%	4%	8%

Source: Minnesota Department of Human Services. (1986, January 31). *Services to Persons with Mental Retardation in the State of Minnesota*. St. Paul: Author.

TABLE 4.1.2.c

Services to Persons with Mental Retardation in Minnesota:
Expenditures by Service Category
(Most Recent Year Available — 1982 through 1985)

Service Category	Medical Assistance (SYF1986)	Community Social Services (CY1985)[a]	State Appropriation (SFY1986)
State Hospitals	$ 96,558,356	$ 212,897	—
ICFs-MR (Community)	$107,332,085	$ 3,028,758	—
Developmental Achievement Centers	$ 17,944,000	$15,654,787	—
Semi-Independent Living	—	$ 709,526[b]	$2,620,800
Waivered Services[c]	$ 5,142,237	—[d]	—
Family Subsidy	—	—	$ 705,000
Other Community Social Services	—	$22,137,581	—
TOTAL	$226,976,678	$41,773,549	$3,325,800

Source: Minnesota Department of Human Services. (1986) *County 1985 CSSA Effectiveness Reports*. St. Paul: Author.

[a]Preliminary estimates based on reported expenditures for persons with mental retardation.

[b]An undetermined amount of CSSA funds was spent for Semi-Independent Living Services clients. These are included in the community social services category. Counties reported a total expenditure of $3,028,758 in CY 1985 for semi-independent living expenses, of which $2,620,800 were state dollars.

[c]Includes payments for screening as well as services.

[d]CSSA funds for "waivered services" are reported under the medical assistance program category.

TABLE 4.1.2.d

Services to Persons with Mental Retardation in Minnesota:
Average Cost Per Person by Service Category
(State Fiscal Year 1986)

Service Category	Average Cost Per Person Per Day/Hour	Average Annual Cost Per Person[a]
State Hospitals	$141.21/day	$51,542
ICFs-MR (Community)	$ 64.41/day	$23,510
Developmental Achievement Centers[b]	$ 31.69/day	$ 6,723
Semi-Independent Living	$ 18.80/hour	$ 4,581
Waivered Services[c]	$ 40.83/day	$14,900
Family Subsidy	$ 7.70/day	$ 2,808
Other Community Social Services	—	—

Source: Minnesota Department of Human Services. (1986) *Medicaid Management Information System*. St. Paul: Author.

[a]Computed: Total Cost of Service Category/Number of Persons Served.

[b]The annual cost of Developmental Achievement Centers is based upon 220 days of services. Over a 365-day period, the average cost would be $12.32/day.

[c]Includes payments for cost of screenings as well as services. The average daily cost of Waivered Services at $40.83 is an estimate by the Mental Retardation Services Division.

TYPE OF DISABILITY	NUMBER IN FOSTER CARE
Mental retardation	448
Emotional handicap	206
Hearing, speech, and sight impairment	88
Physical disability	71
Learning disability	96
Other disability	441
TOTAL	6,282

Foster Care Program:

As of December 31, 1984, there were 6,282 children with disabilities living in licensed foster care homes. This number included those children with mental, physical, and emotional disabilities, as indicated:

Foster parents who care for children with special needs are reimbursed with supplemental maintenance payments (referred to as "Difficulty of Care" payments). Difficulty of Care payments are determined by each local social services agency and based upon an assessment of the child's special needs. This program is funded under Title IV-E, Foster Care Program, of the Social Security Act.

Subsidized Adoption Program:

As of July 1, 1986, 650 children with special needs and 516 families were served by subsidized adoption in Minnesota. This program increased by 23.2 percent over the previous year, serving an additional 117 children.

An adoption subsidy is made available for a child with special needs to provide financial reimbursement for expenses incurred related to the child's special needs. The agency responsible for placing the child determines whether an adoption subsidy is needed to ensure the child an adoptive home.

All children who receive an adoption subsidy are eligible for the benefits of Medicaid (Medical Assistance). The average monthly maintenance payment under this program in fiscal year 1986 was $320. Total expenditures in fiscal year 1986 amounted to $1,223,431 for maintenance, medical, and special costs. In addition, $387,768 was paid out under the Medicaid Program for medical assistance.

Services to Persons Who Are Deaf and Hearing Impaired:

The Deaf Services Division is required by statute to assure that persons with hearing impairments or have multiple handicaps have access to mental health, social, and financial services. Program planning, technical assistance, and training are provided to counties and related agencies which serve an estimated 36,000 persons who are deaf and 105,000 persons who have hearing impairments.

There are eight Regional Service Centers which serve persons who are hearing impaired. These service centers are located in Duluth, Crookston, Fergus Falls, St. Cloud, Willmar, Mankato, Rochester, and Minneapolis. Each Regional Service Center has State Deaf Services Division staff assigned to provide service referral and case management assistance.

Examples of services provided during fiscal year 1986 included:

- There were 972 consultations and trainings provided to county and regional direct staff;
- There were 240 consultations and trainings provided to state departments and state facility staffs;
- There were 2,880 message relay calls facilitated;
- There were 12,000 interpreter referrals completed; and
- There were 10 residents with hearing impairments who were assisted in their transition from a state institution to community support programs.

MINNESOTA DEPARTMENT OF HEALTH

Community Health Services:

Created by the Minnesota Legislature in 1976, the Community Health Services Act provides for the development and maintenance of an integrated system of community health services under local administration operating with state guidelines. The goal of the program is to protect and improve the health of people within a geographically defined community by emphasizing services to prevent illness, disease, and disability. This goal is accomplished by promoting effective coordination and use of community resources and by extending health services into the community. These services include: Community Nursing (which includes Maternal and Child Health), Home Health, Disease Prevention and Control, Health Education, and Environmental Health. Programs are financed by a combination of state, local, and federal funds. The combined reported expenditures in 1984 for the operation of all Community Health Service programs amounted to $86,632,280, a 13.4 percent increase over the 1983 level (Minnesota Department of Health, 1986, p. 8).

As of July 1, 1985, all 87 counties in Minnesota were participating in the Community Health Services system. Of the counties in the program, 18 were participating as single counties, 68 were combined with other counties in a total of 22 multicounty boards, and five cities participated as Community Health Service Boards within two urban counties.

Maternal and Child Health Services:

Program Purpose: The purpose of this activity is to improve the health status of children and youth, women, and their families by providing technical and financial support services to local community health agencies, schools, and voluntary organizations. Services include program planning, goal setting, technical consultation, professional education and training, and grants for specialized purposes. A large portion of the budget is for the purchase of supplemental foods for women, infants, and children. Activities are generally coordinated with one another at the service delivery site so that comprehensive maternal and child health services are provided to individuals.

In 1984, 97,327 home visits were provided for pre- and post-natal services, family planning, parenting and child growth and development services.

Clinic services provided in local health agencies and schools included infant and child health assessment, health maintenance, health promotion, general health screening, Early and Periodic Screening, Early Childhood Health and Developmental Screening, hearing and vision screening, scoliosis screening, and screening for elevated levels of lead (Minnesota Department of Health, 1986, p. 12).

The **Women, Infants, and Children (WIC)** activity, funded by the U.S. Department of Agriculture, provides nutritious supplemental foods and nutrition education to mothers, infants, and children to age five years who are at nutritional risk and enrolled in local WIC programs. The state staff provides standard setting, technical support, grant management, and monitoring for local WIC agencies so that federal requirements are met and quality is assured. The state staff manages an automated financial management system for issuance and reconciliation of vouchers issued to program participants for purchase of foods at authorized grocery stores, drug stores, and dairies.

The **Human Genetics** activity provides counseling for patients and family members with known or suspected genetic diseases, consultation, education, and diagnostic support to physicians and other health professionals, and detection of metabolic diseases in newborns through screening. These services help persons manage genetic diseases and make informed decisions about family planning.

The **Child Health Screening** activity promotes and provides technical support for accessible high quality health and developmental screening for all children in the state. The services are supported by combined state and federal funds provided through the state departments of Health, Education, and Human Services, and administered in communities.

Services for Children with Handicaps (SCH) provides for the identification, diagnosis, and treatment of children with handicapping conditions caused by birth defects, congenital cardiac lesions, hereditary disease, or chronic diseases such as diabetes, cystic fibrosis, or cancer. In fiscal year 1984, services for children with handicaps conducted approximately 285 field clinics throughout Minnesota. Approximately 9,500 children were served by the program. Efforts are made to ensure that children receiving benefits under the SSI Program are aware of services available to them through the Services for Children with Handicaps Program. SCH offers leadership in establishing guidelines and serves as a model for a system of multispecialty care for children with handicaps. This program also serves approximately 1,500 children who receive Supplemental Security Income (SSI).

The purpose of the **Hearing and Vision Conservation** activity is to assure that children with hearing or vision problems are identified at the earliest possible time and arrangements made for treatment and remediation. This goal is accomplished by local and regional personnel using state guidelines, technical consultation and training, and equipment calibration to assure quality service and cost-efficiency. The staff provides public education concerning primary and secondary prevention of hearing and vision problems.

In 1984, all counties were providing **Home Health Care** services to individuals who were ill or disabled and their families. These services provide an alternative to institutional services and are designed to assist restoration of health and to provide the care needed for terminal illnesses. Counties provide skilled nursing and home health aide visits and conduct nursing home preadmission screening and hospital discharge planning activities and administer services. In 1984, there was a total of 283,669 professional home health care visits. The majority of these visits were for skilled nursing care. In addition, there was a total of 335,204 home health aide visits for disease and disability reasons to 8,447 persons with disabilities (Minnesota Department of Health, 1986, p. 18).

Personnel in **Family Planning** work with local public and voluntary agencies to develop quality family planning services and prenatal, postnatal, and perinatal services which increase the potential for healthy pregnancies and newborns. The activity administers family planning grants to community agencies, sets standards, and provides technical support services to community programs. A particular focus of attention is the unplanned adolescent pregnancy.

Maternal and Child Health State Plan: The Maternal and Child Health Plan contains several goals and objectives which relate specifically to people with developmental disabilities:

- Assure that every pregnant woman receives adequate prenatal care to ensure a healthy newborn. Good prenatal care is aimed at preventing poor outcomes for both mother and baby;
- Provide reproductive health education and family planning services to all females and males of reproductive age in Minnesota;
- Reduce poor birth outcomes among Minnesota infants;
  lower the total infant mortality rate from 9.83 per thousand to 9.0 per thousand by 1990,
  lower the black mortality rate from 22.7 per thousand to 12.0 per thousand by 1990,
  lower the infant mortality rate from 14.0 per thousand to 12.0 per thousand by 1990, and
  maintain the infant mortality rate for whites and of East Asian populations through 1990;
- Assure that all children have quality health care services available;
- Encourage all schools to have a curriculum component on education and intervention in suicide, chemical abuse, mental illness, depression, and child abuse by 1990;

- Assure that all adolescents be provided with necessary means to enable them to reach their potential in physical, psychosocial, and emotional development:

  promote the special health concerns of adolescents by 1990, and

  reduce number of teenage pregnancies before 18 years of age from 58.0 per thousand to 29.0 per thousand by 1990;

- Assure that all children with handicaps receive services to assist them in developing and participating to the fullest extent possible in their lives:
  assure that 100 percent of Minnesota counties will continue to have access to statewide network of specialized health services for children with learning and physical handicaps through Services for Children with Handicaps by 1990;
- Assure that all children grow up in a safe, secure, healthful environment:
  assure that 100 percent of Minnesota counties will have injury prevention education including car restraints, seat belts, household accidents, and poisonings by 1990;
- Assure that all Minnesota mothers and children have appropriate health services available and accessible:
  assure that 100 percent of Minnesota's community health services agencies will have a plan for addressing maternal and child health needs in their service area by 1990.

Early Intervention — Interagency Agreement: In July 1984, the commissioners of Health, Education, and Human Services signed an interagency agreement to work collaboratively to improve availability, accessibility, and quality of early intervention services promoting the development of interagency systems. The objectives of the agreement included:

- Increasing public awareness of the rationale and need for early intervention;
- Documenting the cost-effectiveness of interagency cooperation;
- Encouraging and facilitating the exchange of ideas, plans, program models, and resources across disciplines, programs, and agencies at the state and local levels; and
- Verifying issues, defining problems, and proposing alternatives relating to screening and assessment of program models and identifying for the departments of Health, Education, and Human Services changes in fiscal and program policies that may be necessary to improve coordination and comprehensiveness of services.

ICFs/MR Deficiency Reports:

The Developmental Disabilities Act (P.L. 98-527), Section 122 (F)(5)(E), requires that each state must assure that ". . . the state will provide the State Planning Council with a copy of each annual survey report and plan of corrections for cited deficiencies prepared pursuant to Section 1902(a)(31)(B) of the Social Security Act with respect to Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) in such report or plan."

During fiscal year 1986, with full cooperation of the Minnesota Department of Health, 136 reports on ICFs/MR were reviewed. The nature of the deficiencies revealed in the reports on each facility were placed into three categories: physical plant, personnel, and residents.

PHYSICAL PLANT: There were a total of 303 deficiencies among the 136 facilities that related to cleanliness, building repair, and furniture repair or replacement.

PERSONNEL: There were 299 deficiencies relating to personnel. Among the most common were those concerning the administration of Mantoux tests and chest x-rays to new employees. A number of other deficiencies related to incomplete contracts or credentials for persons from whom the facility received professional services for residents.

RESIDENTS: Among the 403 deficiencies cited in relation to residents, the most common pertained to having incomplete records. There were 312 deficiencies related to active treatment.

MINNESOTA DEPARTMENT OF EDUCATION

Special Education Services:

Program Purpose: The Special Education Section, Division of Instructional Effectiveness, Department of Education is the state agency responsible for the provision of mandatory (ages 3 through 21) and permissive (birth through age 2) special education services for students with handicaps.

Authority for the provision of special education services includes, but is not limited to: (1) the Education of All Handicapped Children Act as amended by Public Laws 94-142 and 98-199; (2) Minnesota Statutes 120.03, 120.17, and 124.32; and (3) State Board of Education Rules Chapter 3525.

Funding for special education programs is provided through state, local, and federal sources. State funding comprises 60.9 percent; local, 29.7 percent; and federal, 9.4 percent according to statistics compiled from fiscal year 1984 data (Minnesota Department of Education, 1985, p. 74).

Clientele: Mandatory (ages 3 through 21) and permissive (birth through age 2) special education services are provided by local education agencies (LEAs). During the 1984-85 school year, just over 81,000 students received some type of special education services. See Table 4.1.2.e.

Special Education State Plan: The major goal for this plan is to provide full educational opportunities to all handicapped children in Minnesota birth through age 21. The plan lists how the State Education Agency (SEA) will use Public Law 94-142, Part B Funds. The funds will be used to accomplish the following:

- Determine policies for use of Public Law 94-142, Flow through Funds, Discretionary Funds, and Preschool Incentive Grants;
- Improve the management capacity of application systems, child count, analysis, and information dissemination for use of federal funds;
- Provide information for and receive information from the advisory council;
- Prepare state plans to secure federal funds for services for handicapped students;
- Review applications and award funds from Public Law 94-142, Flow through Funds, Discretionary Funds, Preschool Incentive Grants, and other funds related to services for students with handicaps;
- Provide advice to the Legislature on rules and other issues as requested;
- Provide advice on licensure review and state college programs;
- Monitor local programs for compliance;
- Provide advice on and implement interagency agreements;
- Coordinate roles and rules with vocational education and Part IV.C Funds;
- Continue development and implementation of evaluation system; and
- Explore the use of emerging technology in special education instruction and management.

Five percent of the Public Law 94-142, Part B Funds will be used for the activities outlined above. At least 75 percent of the Public Law 94-142, Part B Funds will be used for projects of local districts or cooperatives, "flow through" projects. The difference between monies used for administration and "flow through" projects will be used for discretionary grants. Discretionary funds will be used to:

- Plan, implement, and coordinate regional multicooperative services for students with low incidence handicaps;

- Explore new directions in service delivery through extension of mini-grants in the areas of evaluation systems and use of technology, creative approaches to cost-effective service delivery, and personnel training; and
- Develop an ongoing data flow system for evaluation of special education programs in fiscal years 1984-86; with possible use of discretionary funds, expansion of existing telecommunication systems, exploring options to enhance programming in the area of emotional behavioral disorders, and finally, exploring ways in which mildly handicapped students can be served within regular mainstreamed classes.

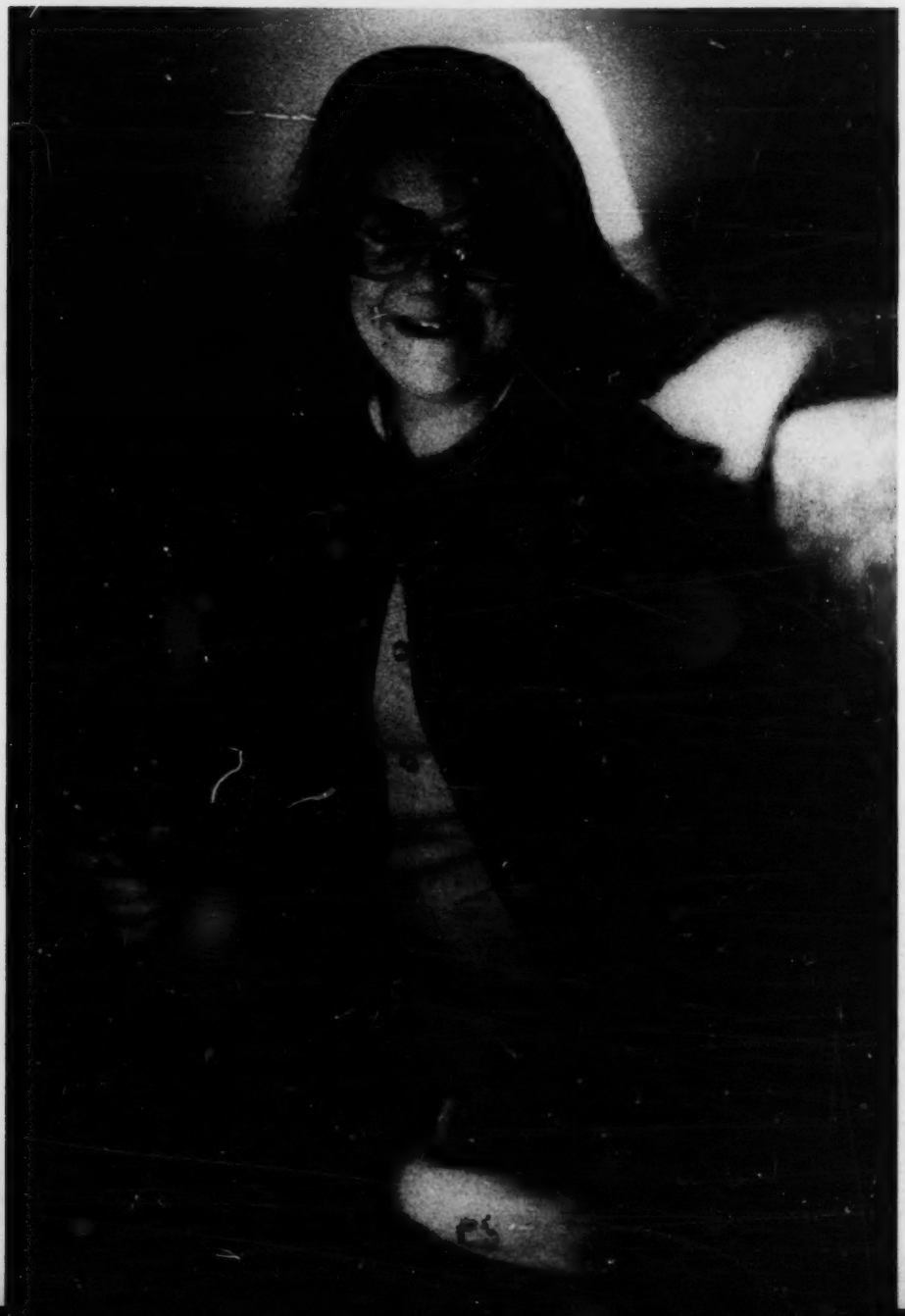


TABLE 4.1.2.e

Unduplicated Child Count: Number of Children and Youth Receiving Special Education and Related Services in Minnesota by Age Category and Primary Disability in School Year 1985-1986

	AGES								
PRIMARY DISABILITY	**Birth-2**	**3-5**	**6-8**	**9-13**	**12-14**	**15-17**	**18-21**	**Over 21**	**TOTAL**
Speech Impairment	106	5,259	7,466	4,395	1,184	393	60	0	18,863
Educable Mental Retardation	76	690	1,407	1,633	2,055	2,243	560	1	8,665
Trainable Mental Retardation	46	353	594	547	622	798	812	8	3,780
Physical Handicaps	107	272	373	251	236	191	48	0	1,478
Hearing Impairment	45	200	326	298	252	226	49	0	1,396
Visual Handicaps	42	74	81	67	72	69	12	1	418
Learning Disabilities	49	829	6,293	10,203	9,946	8,712	1,179	8	37,219
Emotionally Disturbed	3	264	759	1,498	2,763	3,231	339	0	8,857
Deaf/Blind	4	4	2	1	2	4	4	0	21
Other Health Impairments	35	173	151	102	136	119	13	0	729
Autistic	1	28	33	39	18	16	17	0	152
TOTAL	514	8,146	17,485	19,034	17,286	16,002	3,093	18	81,578

Source: Minnesota Department of Education (December 1, 1985).

Office of Transition Services: As authorized by the 1985 Minnesota Legislature, the Department of Education recently established an Interagency Office on Transition Services. The purpose of this new statewide program is to address the needs of students with handicaps as they progress through school and enter postsecondary training, employment, and community living.

Some of the responsibilities of this office include:

- Providing staff to the State Transition Interagency Committee, consisting of representatives from special education, rehabilitation services, vocational education, human services, community colleges, consumers/advocates, and developmental disabilities. This committee is currently finalizing an interagency agreement;
- Coordinating personnel training and developing in-service training programs;
- Providing information, consultation, and technical assistance to state and local agencies about transition services;
- Assisting agencies in establishing local interagency agreements to assure the necessary services for the efficient and appropriate transition from school to work or postsecondary training programs; and
- Gathering and coordinating data on transition services for secondary age students with handicaps.

Transition from School to Work and Community Living:

The Developmental Disabilities Act of 1984 (P.L. 98-527), Section 122(b)(4)(D), requires that "The plan must be developed after consideration of the data collected by the State education agency under Section 618(b)(3) of the Education of the Handicapped Act." The Minnesota Department of Education is required to include in its evaluation of special education programs "the number of handicapped children and youth exiting the educational system each year through program completion or otherwise, by disability category and age, and anticipated services for the next year."

Table 4.1.2.f summarizes the estimated number of students, ages 15 and over, who have left special education services each year since 1981. Among all special education students, there were approximately 4,260 to 5,860 students leaving the special educational system each year. A substantial number of these students have learning disabilities (approximately 45 percent) and speech impairments (3.7 percent). This population is not as likely to need further intensive services as they leave school as would those with more substantial types of handicapping conditions.

TABLE 4.1.2.f

Estimated Number of Students Who Leave Special Education in Minnesota: 1981-1985 (Ages 15 and Over)

YEAR	TOTAL LEAVING SPECIAL EDUCATION	LEAVING WITH SUBSTANTIAL HANDICAPS*
1981	4,821	2,473
1982	5,377	2,737
1983	4,262	2,086
1984	5,863	3,008
1985	5,745	2,947

Source: Minnesota Department of Education, Unduplicated Child Counts 1980 through 1985.

*This number includes students with mental retardation, physical handicaps, hearing impairments, visual handicaps, autism, and those who are deaf-blind, emotionally disturbed, or have other health impairments.

This number excludes the number of students with learning disabilities (which comprise 45.0 percent of the special education population) and speech handicaps (which comprise 3.7 percent).

Table 4.1.2.f takes into consideration the population with the most substantial handicapping conditions such as mental retardation, physical handicaps, hearing and visual impairments, and autism. The number of students with learning disabilities and speech impairments, who often improve in performance through remedial services, were subtracted from the total number of students who are estimated to leave school each year. Therefore, it is estimated that at least 2,000 and as many as 3,000 students leave school each year who may need special, supportive assistance by the adult service system. (Minnesota Department of Education, *Unduplicated Child Counts*, 1980 through 1985)

During the next few years, the Minnesota Department of Education, the Office of Transition Services, and the University Affiliated Program at the University of Minnesota will be working cooperatively to improve data collection and information which will more completely describe the service needs of the students who will be leaving school and entering training, employment, and community living.

Secondary Vocational Education Services:

The Secondary Vocational Education Unit of the Minnesota Department of Education is the state agency responsible for the administration of vocational education programs. Local education agencies (LEAs) apply annually to the Minnesota Department of Education for program and funding approval. State law requires that federal vocational funds are to be added to the state allocation. These federal funds for students with handicaps are distributed to the LEAs on a formula basis. Mandatory special vocational education programs and services are provided by local education agencies for all students with handicaps requiring a modified vocational education program, a specially designed vocational program, and/or are in need of special vocational education assistance. The students who receive special vocational education services and programs must have one or more handicapping conditions as defined by the Special Education Section of the Minnesota Department of Education.

Preschool Incentive Grant Program:

History and Purpose: During the past several years, local school districts in Minnesota were mandated by the Legislature to serve all children with handicaps starting at age four. By September 1986, all school districts must serve children with handicaps starting at age three. Funding is also available to school districts if they serve children with handicaps from birth through two years of age on a permissive basis. Recent efforts by advocacy organizations to promote the passage of legislation that would mandate services to children from birth have not succeeded, primarily due to state budget constraints. Presently, 243 school systems are voluntarily providing early intervention services to children from birth to age three and their families, which comprise about half of all school districts. During fiscal year 1985, 8,660 children from birth through age five were served by local educational agencies.

The **Preschool Incentive Grant** plan goals include:

- Increase the quality and quantity of services available to children birth through five years of age and improve strategies to identify, locate, and evaluate all handicapped children age birth through five years of age;
- Improve administrative supports to maximize services to these children;
- Train parents in child development and the special needs of their children with handicaps through interagency cooperation with the departments of Health and Human Services;
- Promote the development of comprehensive services for children with handicaps from birth; and
- Improve the transition of young children with handicaps into kindergarten. The plan also lists specific objectives to be carried out by the state preschool consultant.

The rationale for early infant intervention services for children with handicapping conditions is based upon developmental and psychological research which indicates:

1. Human behavior at any point represents a series of elaborations of previous behavior from simple to complex beginning at birth.
2. The acquisition of motor, cognitive, and language skills is interrelated.
3. Social behaviors are learned as early as infancy.
4. Failure to learn may also begin at birth.

The Governor's Planning Council on Developmental Disabilities has been on record in support of early intervention for the past several years. In 1986, the Council produced a glossy poster distributed to over 1,500 individuals and agencies that was mailed with a Governor's proclamation and cover letters from Sherburne and Northern Wright County Special Education Cooperative and Independent School District No. 16.

STATE BOARD OF VOCATIONAL-TECHNICAL EDUCATION

In recent years vocational training has been made available to persons with handicapping conditions in Area Vocational-Technical Institutes (AVTIs). In Minnesota there are 30 AVTIs located at 34 locations throughout the state. The AVTI system is supported by funds from state appropriations, federal aid, and student tuition. The approximate contribution to the system from each of these sources is 68 percent state appropriations, 7 percent federal aid, and 25 percent student tuition.

The occupational programs of the AVTIs provide students with:

1. Initial job training or retraining of the skills necessary for a particular job.
2. An opportunity to improve or upgrade current job skills.
3. A chance to explore other careers.
4. An opportunity for personal or professional development.

Student Population: In fiscal year ending June 30, 1985, there were 1,675 students with handicapping conditions enrolled in vocational education/postsecondary programs. There may also be a number of students who have handicaps but were listed among the 11,771 students who were classified as "disadvantaged."

The term "handicapped" refers to individuals who are mentally retarded, hearing impaired, deaf, speech-impaired, visually-handicapped, seriously emotionally disturbed, orthopedically-impaired, or other health-impaired persons, or persons with specific learning disabilities, who by reason thereof, require special education and related services, and who, because of their handicapping condition, cannot succeed in the regular vocational education program and reasonable accommodations need to be made.

Vocational Education State Plan: The Vocational Education State Plan contains 80 objectives. The following partial list of objectives directly or indirectly affect persons with developmental and other disabilities:

- Provide vocational programs for all secondary students including those with handicaps;
- Provide secondary students with handicaps and related conditions with the opportunity to enroll in regular vocational programs and receive support services;
- Provide opportunity for community-based experience for secondary students with handicaps;
- Provide aptitude and ability assessments to help students with handicaps and related conditions make better career choices; and
- Provide secondary vocational employment services and a directory of job resources and instruction in employment skills and placement after high school.

LEGAL ADVOCACY FOR DEVELOPMENTALLY DISABLED PERSONS IN MINNESOTA

Role of the Agency and Major Responsibilities: The role of Legal Advocacy for Developmentally Disabled Persons in Minnesota is to protect and advocate for the rights of persons with developmental disabilities. The Project staff concentrate on direct representation of people with disabilities, legislative and administrative advocacy, and consumer and professional education and training. A major focus of legal advocacy services is to assure that quality community-based services are available for people with developmental disabilities.

The Developmental Disabilities Act of 1984 requires that each state have in effect a system to protect and advocate for the rights of persons with developmental disabilities, and appropriates money for that purpose.

Legal Advocacy, a project of the Legal Aid Society of Minneapolis, has been designated by Governor Perpich as the Minnesota Protection and Advocacy agency.

Legal Advocacy is funded by the Administration on Developmental Disabilities of the United States Department of Health and Human Services, the United Way, grants from several foundations, and personal contributions.

In federal fiscal year 1985, there were 776 individuals with developmental disabilities served. In addition, there were 2,650 individuals represented under the *Welsch* Consent Decree.

Client Assistance Project:

Role of the Agency and Major Responsibilities: The Client Assistance Project provides information, support, and advocacy services to clients and potential clients of the Division of Rehabilitation Services and State Services for the Blind to ensure that they receive the services and benefits available to them as provided by the Rehabilitation Act of 1973.

Section 112 of the Rehabilitation Act of 1973, 29 U.S.C. Section 732, requires that the Governor designate a public or private agency to assist clients and potential clients of rehabilitation programs. Governor Rudy Perpich designated the Legal Aid Society of Minneapolis, Inc., to fulfill that function.

The Client Assistance Project is funded by a grant from the Rehabilitative Services Administration of the United States Department of Education, pursuant to Section 370.2 of the Rehabilitation Act of 1973, as amended.

In fiscal year 1985, there were 372 individuals served by the Client Assistance Project.

MINNESOTA UNIVERSITY AFFILIATED PROGRAM ON DEVELOPMENTAL DISABILITIES

Program Purpose: The Minnesota University Affiliated Program (UAP) was established in February 1985 to provide interdisciplinary training, exemplary services, and information and referral for Minnesota's citizens with developmental disabilities, their families, services providers, and communities. The Minnesota UAP joins a network of University Affiliated Programs across the United States.

The Minnesota UAP evolved through cooperation of the University of Minnesota and the Gillette Children's Hospital Developmental Disabilities Program. It reflects statewide commitment to individuals with developmental disabilities in the state.

Program priorities are reviewed by both faculty and community advisory committees. Close working relationships exist with the state Developmental Disabilities Council and other state agencies. The Minnesota UAP began as a satellite center and has now been given full status.

The mission of the Minnesota UAP is to:

- Maximize the opportunity of citizens with developmental disabilities to experience the benefits of family and community living, while receiving services needed to develop their full potential for personal independence, self-care, and social participation; and
- Improve the quality and community orientation of professional services and social support to persons with developmental disabilities and their families.

A major emphasis in the design of the Minnesota University Affiliated Program is upon interdisciplinary training. Extensive opportunities for training experiences are provided for individuals in many different areas. Formal course work is available for students who have not yet started their careers. Placement services are also provided to help students in a variety of disciplines acquire relevant experiences in working with individuals with developmental disabilities. In-service training is available for those who are already working with individuals with developmental disabilities but who want to update their skills or add to them. Conferences of interest to parents and family members, managers, and policy makers also are provided.

Exemplary services are provided by the Minnesota UAP in the Gillette Hospital Developmental Disabilities Program and in numerous community-based programs. Emphasis is placed on several areas:

- Strengthening interdisciplinary clinical services to improve training experiences;
- Expanding the statewide availability of adult evaluation services;
- Improving community management of physical and medical needs; and
- Enhancing the capacity of service agencies to provide training and other services using more normal environments.

Among the 347 new individuals diagnosed and served between July 1, 1985, and June 30, 1986, at Gillette Hospital, 126 were found to have mental retardation, 48 had a seizure disorder, 17 had autism, and 144 had a motor disability.

Information, dissemination, and research systems are integrated into both the training and exemplary services components of the Minnesota UAP:

- Addressing the concerns of personnel who provide direct services to persons with developmental disabilities;
- Providing researchers and government agencies with information for further training-related and service-related research; and
- Optimizing the flow of information within the UAP network and for use in Minnesota.

4.2
What Are the Council's Major Concerns during the Three-Year Plan Period?

The Council's selection of major concerns for this three-year plan was shaped by several factors: awareness of federally mandated responsibilities under Public Law 98-527; assessment of statewide needs in each priority area; final selection of a priority area; and recognition of decision-making processes that affect service delivery in the chosen priority area.

4.3
What Are Priority Service Areas?

The federal Developmental Disabilities Act requires each state to assess the service needs of all citizens with developmental disabilities with special emphasis on four service areas identified in the legislation. These four areas are listed and defined in paragraph 4.3.1.

The Act further requires each state Developmental Disabilities Council to commit at least 65 percent of the federal allotment to "service activities" in at least one but not more than three of the federal priority service areas. Beginning in FY 1987, Employment-Related Activities must be selected by each state as a priority service area.

The process for selection of the state's priority service area(s) and justification are provided in paragraph 4.3.2. The current priority service areas are discussed in paragraph 4.3.3.

4.3.1
The Federal Definitions of Priority Service Areas and the Elements of Those Services as Defined in Minnesota

1. Case Management:

Services which will assist persons with developmental disabilities in gaining access to needed social, medical, educational, and other services; includes follow-along services which ensure a continuing relationship, lifelong if necessary, between a provider and a person with developmental disabilities and the person's immediate relatives or guardians; includes coordination services which provide support, access to and coordination of other services, information on programs and services, and monitoring of progress. (Section 102(H)(i)(ii))

Elements of Case Management Services in Minnesota: In Minnesota's county-based social service delivery system, primary responsibility for providing case management services to people with developmental disabilities rests with county social service agencies. The Community Social Services Act (CSSA) established county responsibility for the planning and provision of community social services to seven mandated groups of people including people with mental retardation or related conditions "who are unable to provide for their own needs or to engage independently in ordinary community activities."

Under the CSSA, county board authority includes contracting for or directly providing: (1) an assessment of the needs of each person applying for services which estimates the nature and extent of the problem to be addressed and identifies the means available to meet the person's need for services; (2) protection for safety, health, or well-being by providing services directed at the goal of attaining the highest level of independent functioning appropriate to the individual preferably without removing those persons from their homes; and (3) a means of facilitating access by persons with physical handicaps to services appropriate to their needs. (Minn. Stat. § 256E.08, Subd. 1)

Minnesota Department of Human Services Rule Parts 9525.0015 to 9525.0165 further defines county case management responsibilities with regard to people who are mentally retarded or have related conditions. The rule defines the purpose of case management as "identifying the need for seeking out, acquiring, authorizing, and coordinating services to persons with mental retardation or related conditions." Case management services include monitoring and evaluating the delivery of the services to, and protecting the rights of, persons with mental retardation or related conditions.

2. Child Development Services:

Child Development Services are services which assist in the prevention, identification, and alleviation of developmental disabilities in children. The services include early intervention, counseling and training of parents, early identification, and diagnosis and evaluation. (Section 102(G))

Elements of Child Development Services in Minnesota:

- **Early Identification, Diagnosis, and Evaluation Services:** Statewide, there are three comprehensive child screening programs whose purpose is the early identification of developmental and physical problems. These programs are Early and Periodic Screening (EPS); Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); and Preschool Screening (PSS). They are administered by the departments of Health, Human Services, and Education, respectively, and maintain a shared reporting system.

  A variety of health promotion and prevention services are provided through Community Nursing and Maternal and Child Health Services under the Community Health Services Act in Minnesota. In 1983, a total of 426,374 visits were made to infants, children, and women for screening, education, referral, and treatment services. Services were provided in homes, clinics, and schools. The largest number of visits (324,355) was for services provided for child growth and development, which included 53,487 health promotion visits and 271,361 child health screening visits for Early and Periodic Screening (EPS), Preschool Screening (PSS), hearing, vision, and scoliosis. In addition, Community Health Services (CHS) provided school health services, such as dental screening, preschool screening, hearing and vision screening, scoliosis screening, and school health education. In 1983, 208,855 contacts were made with school-age children through the vision and hearing screening program alone. (Minnesota Department of Health, 1985, pp. 22-23)

  Services for Children with Handicaps (SCH), within the Maternal and Child Health Division of the Minnesota Department of Health, is an additional statewide resource for the identification, diagnosis, and treatment of children with handicapping conditions. The SCH program provides field clinics and arranges for diagnostic and treatment services in medical centers.

  In addition to these statewide resources, private physicians, clinics, hospitals, public health agencies, and rehabilitation centers do screening and diagnosis of children with developmental disabilities.

- **Early Intervention Services:** In 1984, there were nearly 11,000 children (birth through age five) receiving early intervention services in Minnesota. Public schools, developmental achievement centers, and Head Start provide services to children in this age group. Over half of all school districts (N = 243) voluntarily provide services to children from birth to age three. Starting in the fall of 1986, all school districts will be required to serve children at age three. Of the 108 developmental achievement centers in Minnesota, 53 serve 2,284 children from birth to age 3. Parent counseling and training agencies are provided by developmental achievement centers, advocacy organizations, and community social service agencies. (Minnesota Governor's Planning Council on Developmental Disabilities, 1986, p. 1)

3. Alternative Community Living Arrangement Services

These are services which will assist persons with developmental disabilities in maintaining suitable residential arrangements in the community including: in-home services (such as personal care attendants and other domestic assistance and supportive services), family support services, foster care services, group living services, respite care, and staff training, placement, and maintenance services. (Section 102(D))

Elements of Alternative Community Living Arrangement Services in Minnesota: In Minnesota, the range of alternative community living arrangement services includes:

- **In-Home Family Support Services:** Includes the provision of services such as homemaking assistance, respite care, parent training, and support groups to families with members who are developmentally disabled. Sources of funding include the Minnesota Family Subsidy Program, county human services boards, and advocacy groups.

- **Semi-Independent Living Services (SILS):** The provision of SILS involves placement of adults in small units where they are supervised by a licensed agency and provided with services based on need including: training in cooking, shopping, hygiene, and using public transportation. The purpose of SILS is to prepare individuals for independence or to maintain individuals in semi-independence. SILS room and board are paid from: SSI, SSI/MSA, Social Security, Section 8 (HUD), General Assistance, wages, food stamps, and combinations of these. In 1986, approximately 1,060 adults with developmental disabilities were receiving semi-independent living services in 80 licensed facilities in Minnesota.
- **Foster Care Services:** Foster care services are provided for children who cannot live with their families and for adults who could benefit from a family setting. For child foster care, licensing standards require special provider training and experience and written individual programs. Foster care costs are paid in three ways: (a) private pay by clients, (b) SSI/MSA funds, and (c) general assistance. In 1986, approximately 550 adults and children with developmental disabilities were receiving foster care services in 285 licensed foster homes in Minnesota.
- **Group Living Services:** In Minnesota, group homes are usually certified as Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). Residents are provided with a plan of care with active treatment and 24-hour supervision. Costs are paid by the federal government (52.2 percent), the state (43.0 percent), and the county (4.8 percent). As of January 1, 1986, there were over 5,000 persons with developmental disabilities living in 348 licensed residential facilities in Minnesota.
- **Supported Living Arrangements for Adults:** These services are provided to adults with mental retardation who require up to and including 24-hour supervision, assistance, or training. Services are provided in a person's place of residence, specialized adult foster homes, or group homes for up to six persons.
- **Supported Living Arrangements for Children:** These are the provisions of habilitation services to children and adolescents who have severe developmental problems, medical conditions, behavior or emotional problems, and/or physical handicaps which result in a family's inability to maintain them in their home. These out-of-home services are provided in family style settings for up to three children.

4. Employment-Related Activities

This priority service area refers to those services that will increase the independence, productivity, or integration of a person with developmental disabilities in work settings, Section 102(11)(E), such as:

- **Developmental Achievement Centers:** Programs focused on community integration, job skills, and similar activities. Some centers provide opportunities for work as part of crews, enclaves, or supported work placements.
- **Work Activity Programs:** Programs that provide paid work and other services which allow a level of production below that required for a long-term employment program.
- **Supported Employment Programs:** Programs whose purpose is to place persons who are developmentally disabled in jobs in the community for pay and to provide support as long as is necessary to enable the person to retain the job.
- **Sheltered Workshops:** Work-oriented programs whose primary purpose is to secure current employment in a sheltered setting and/or future competitive employment (typically serves vocational rehabilitation clients and may provide evaluation, work adjustment, other vocational services, and external sheltered work positions).
- **Competitive Placement Programs:** Programs whose only purpose is to provide short-term training leading to placement in competitive employment and short-term follow-up after placement. (Programs providing remunerative work and placement services should be considered sheltered workshop programs.)
- **Competitive Employment:** Part-time or full-time work for real pay with short-term support.

Each of these types of day programs has objectives which are compatible with the federal definition of "employment-related activities." These objectives include:

- **Increasing Independence:** Increase individual functioning within normal community activities and promote opportunities for individuals to exert control and choice over their own lives without support.
- **Increasing Productivity:** Increase the level of individual income, employment status, or job advancement; or the amount of work which contributes to a household or community.
- **Increasing Integration:** Increase the time individuals spend in community activities in contact with other community members and in a manner typical of other members of the community.

4.3.2
The Process by Which Minnesota's Priority Service Area Is Selected

The process of identifying Minnesota's priority service area for this plan began in February 1985 when the Governor's Planning Council on Developmental Disabilities discussed ways to obtain input from concerned Minnesotans. It was decided to hold twelve public meetings throughout the state to take testimony from as many people as possible. (See Section 7, Appendix, for additional information.) Invitations to provide testimony were mailed to over 2,000 individuals and organizations, and a general notice of the meeting was printed in the *State Register.* Testimony was solicited on five questions:

- What is the current status of the priority from your point of view? Discuss innovations, successes, and barriers.
- Which of the four priorities should the Council choose as the focus for the grants?
- What outcomes should the grants be expected to achieve?
- Who should be considered an eligible applicant?
- How can the grants be used to change the "system" or have a long lasting effect?

4.3.3
Minnesota's Priority Service Areas

Through the process described in paragraph 4.3.2, Minnesota selected case management for special emphasis in addition to the mandatory employment-related activities priority.

The selection of case management was influenced by several factors including:

- Recognition that quality case management is fundamental to appropriate placements;
- Concern about the ability of the existing system to deal adequately with increased number of placements of individuals with special needs; and
- Consumers, families, and guardians need information about current state-of-the-art practice.

The Council's primary area of concern is the quantity and quality of case management throughout the state. Specific concerns in the area include:

- The different definitions of case management used throughout Minnesota;
- The lack of knowledge about the people who are doing case management and the process by which it is being done;
- Current case management is often associated with providers;
- Parents and consumers are not always aware of what constitutes good case management; and
- Techniques that could increase the amount of time case managers spend with their constituents have not been widely adopted.

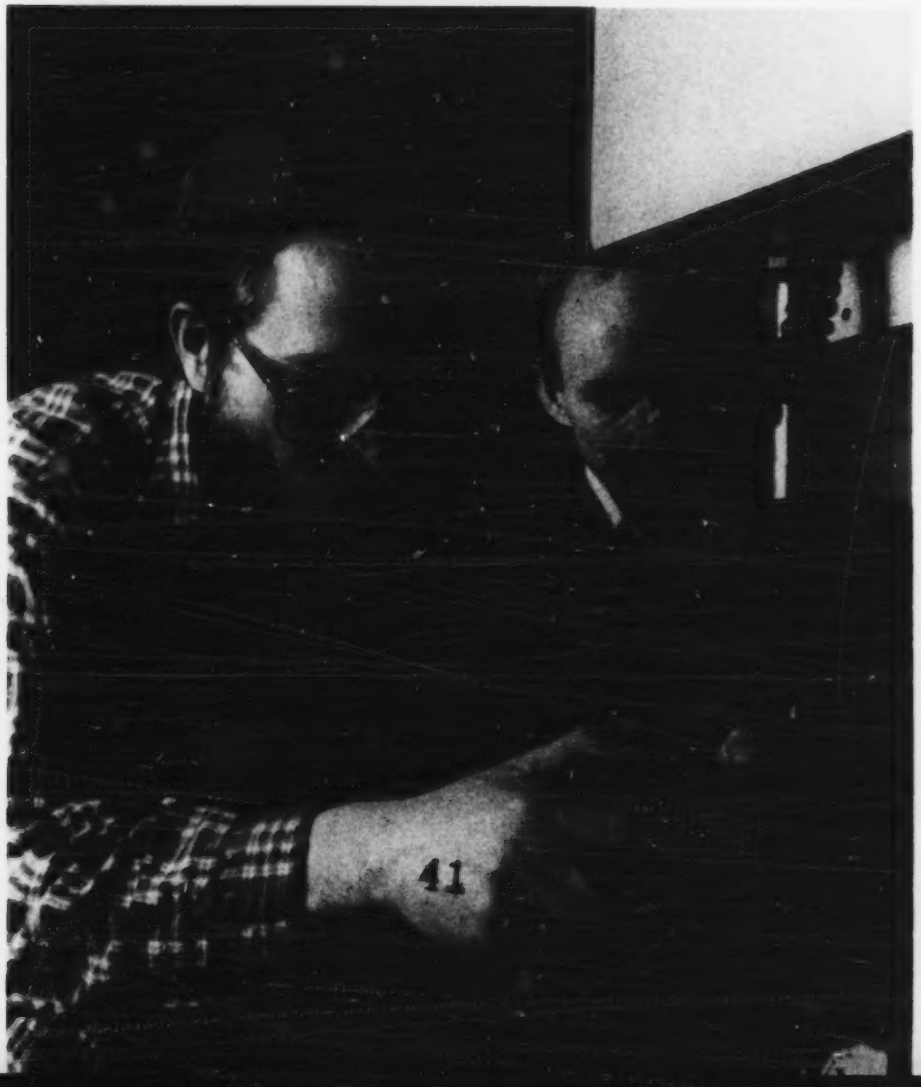
Testimony from the public meetings has been summarized in Section 7.1 as an attachment to this plan.

Witnesses articulated a wide range of needs and made several suggestions for improving the service system for persons with developmental disabilities.

At the August 7, 1985, Council meeting, the results of the testimony from the public meetings were reviewed. The Council members then met in small groups to discuss the four priorities. After each group reported on its discussion, a vote was taken to determine the priority area for the next three-year plan. The result was a tie between Child Development and Case Management. A runoff vote between the two resulted in Case Management being selected as the priority.

Following selection of the priority area, staff prepared a position paper for discussion by the Grant Review Committee and the Council at their meeting, October 2, 1985. The Council was asked to provide comments to staff by November 1, 1985. The staff then prepared a Request for Proposals (RFP) that was reviewed by the Grant Review Committee and the Council at the December 4, 1985, meetings. Minor changes were made and the RFP was mailed to over 1,300 individuals and organizations in Minnesota. The RFP was also announced in the *State Register.*

Proposals were due on April 18, 1986. Sixteen proposals were received. The Grant Review Committee reviewed all the proposals and recommended that six be funded. The Council concurred in the recommendations, and the projects began October 1, 1986.



SECTION 5:
Goals, Objectives, and Funding

The Council's goals, objectives, and funding allocations are presented in Section 5.1. The following activities are carried out with 30 percent of the basic state grant allocation.

Activities Using Federal Administrative Funds:

- Carrying out policy studies related to developmental disabilities and conducting policy briefings with the Legislature, counties, and the executive branch. This set of activities will consist of research and policy analysis activities such as conducting surveys and compiling data from secondary sources. Policy analysis papers on timely issues will be published and distributed.
- Increasing public awareness about developmental disabilities through training, interagency meetings, public education, and technical assistance. These activities promote understanding of developmental disabilities programs throughout Minnesota. Activities will include: (a) sponsoring and/or coordinating training activities on topics related to developmental disabilities; (b) serving on 25 interagency task forces in the departments of Health, Human Services, Jobs and Training, and Education; (c) publishing a monthly newsletter and distributing to over 2,000 people; (d) making over 100 public presentations about developmental disabilities annually; (e) carrying out special initiatives, such as the prevention of disabilities and planning for services to persons who are elderly; and (f) providing technical assistance in response to over 100 requests per month.
- Providing review and comment on federal and state plans, existing laws, proposed legislation, and administrative regulations. These activities meet the mandates of Public Law 98-527 by influencing policy through review and comment procedures. Activities will include: (a) passing resolutions by the Council on developmental disabilities issues; (b) providing comment on proposed bills and rules relevant to developmental disabilities; (c) attending legislative hearings; (d) monitoring of *Federal* and *State Registers* and *Commerce Business Daily* on a regular basis; (e) monitoring deficiency reports issued by the Minnesota Department of Health relating to Intermediate Care Facilities for Persons with Mental Retardation; and (f) reviewing state statutes and regulations related to developmental disabilities.

The goal of the Council is to ensure that persons with developmental disabilities have a **coordinated** and **comprehensive** range of services that is **assured**, **available**, and **delivered**. The services promote:

Quality of life;
Quality of services;
Self-sufficiency;
Integration;
Productivity; and
Independence.

As a result of this grant program, the **efficiency**, **responsiveness**, and **measurable effectiveness** of case management should improve by 1989.

5.1
What Are the Council's Plan Year Objectives?

Council's Plan Year Objectives are identified in Table 5.1.a, Table 5.1.b, and Table 5.1.c.

Projected accomplishments under this goal include:

1. By September 30, 1987, Minnesota will have a definitive description of quality case management services and the specific functions which contribute to integration, productivity, and independence of people with developmental disabilities.
2. By September 30, 1989, as a result of the implementation of efficiency efforts, there will be an increase in the amount of time spent by case managers with people with developmental disabilities and family/guardians.
3. By September 30, 1989, management tools will be available statewide to increase the consistency of case management approaches.
4. By September 30, 1989, consumer, advocate, and professional knowledge of state-of-the-art practices in case management will increase.
5. By September 30, 1989, Minnesota will have developed volunteer monitoring committees comprised of citizens, public officials, families, guardians, and other volunteers to visit traditional and alternative programs, report on observations, and influence program quality.

6. By September 30, 1989, one or more model multiagency and/or multicounty case management systems will be in place in Minnesota.

7. By September 30, 1989, choice and decision making related to case management will increase for people with developmental disabilities and families, advocates, and guardians.

The Council will also be soliciting proposals that will investigate problems with funding employment opportunities in the regular work place for persons with developmental disabilities. As a result of this project, the Council will have a clearer understanding of the actions that will need to be taken to further encourage the placement of persons who have developmental disabilities into jobs in the community.

TABLE 5.1.a

Plan Year Objectives
(Section 133(b)(2)(A))

1. **Goal:**
   By 1989, the efficiency, responsiveness, and measurable effectiveness of case management services for persons with developmental disabilities will increase.

2. **Three-Year Objective:**
   To improve the ability of the case management system to respond to individual needs of persons with developmental disabilities.

3. **Plan Year Objective:**
   To understand the current state-of-the-state regarding case management services in Minnesota; to improve the efficiency of case management services; to increase the role of the consumers and families in decisions relating to quality case management services; and to increase volunteer monitoring of services.

4. **Plan Year Objective Activities:**
   - Research;
   - Volunteer monitoring;
   - Training;
   - Technical assistance;
   - Grant management; and
   - Interagency collaboration and coordination.

5. **Outcome Indicators:**
   Participation of consumers in case management process, changes in case manager's time spent on other than client-related activities, changes in quality of case management services provided to clients.

6. **Projected Plan Year funding:**
   Local $326,855 + Federal $487,406 = Total $814,261.

7. **Priority Service Area:**
   Case Management Services.

8. **Description of Subgrantee or Implementing Agency:**
   County social service agencies, institutions of higher education, and consumer agencies.

9. **Expected Effects on the Extent and Scope of Services:**
   Places emphasis on improvement to the quality of case management services, places emphasis on increasing the quality of the time spent by case managers with the clients, places emphasis on involvement of the consumer in the case management process.

10. **Evaluation Method:**
    Quarterly program and financial reports, site visits, and presentations to the Governor's Planning Council on Developmental Disabilities.

TABLE 5.1.b

Plan Year Objectives
(Section 133(b)(2)(A))

1. **Goal:**
   By 1989, the efficiency, responsiveness, and measurable effectiveness of case management services for persons with developmental disabilities will increase.
2. **Three-Year Objective:**
   To influence state and local decision making regarding case management and issues related to developmental disabilities.
3. **Plan Year Objective:**
   To develop background information and policy briefing documents; to build coalition around case management and issues related to developmental disabilities.
4. **Plan Year Objective Activities:**
   Coordination of activities and organizations; publication of policy briefing book.
5. **Outcome Indicators:**
   State and local decisions to improve efficiency, responsiveness, and measurable effectiveness of case management services.
6. **Projected Plan Year funding:**
   State $25,921 + Federal $77,762 = Total $103,683.
7. **Priority Service Area:**
   Case Management Services.
8. **Description of Subgrantee or Implementing Agency:**
   University of Minnesota, Center for Educational Policy Studies or equivalent.
9. **Expected Effects on the Extent and Scope of Services:**
   The briefing book is used for several purposes such as training activities for legislators and boards of county commissioners.
10. **Evaluation Method:**
    Regular meetings with the subgrantee, quarterly reports.

TABLE 5.1.c

Plan Year Objectives
(Section 133(b)(2)(A))

1. **Goal:**
   By 1989, employment opportunities for persons with developmental disabilities will increase.
2. **Three-Year Objective:**
   To identify funding practices that can be coordinated to improve employment opportunities for persons who are developmentally disabled and to develop a strategy for mixing and matching the funding streams.
3. **Plan Year Objective:**
   To identify funding sources and the potential for coordination.
4. **Plan Year Objective Activities:**
   - Research; and
   - Publication of research.
5. **Outcome Indicators:**
   Federal, state, and local decisions to develop coordinated funding for employment programs. Placement of persons who are developmentally disabled into employment in the community.
6. **Projected Plan Year funding:**
   Local $16,737 + Federal $39,850 = Total $56,587.

7. **Priority Service Area:**
   Employment Related Activities.

8. **Description of Subgrantee or Implementing Agency:**
   University of Minnesota, Hubert H. Humphrey Institute of Public Affairs.

9. **Expected Effects on the Extent and Scope of Services:**
   The research will be used to develop strategies to mix and match funding streams.

10. **Evaluation Method:**
    Quarterly program and financial reports, site visits, and presentations to the Governor's Planning Council on Developmental Disabilities.

5.2
What Is the Developmental Disabilities Program's Projected Budget for FY 1987?

The projected expenditures for FY 1987 for the Developmental Disabilities Program are displayed in Table 5.2. The actual allotment and expenditures will be reported in the quarterly financial status report, in plan-year budget revisions, and at the close of the fiscal year as part of the Annual Report.

The state of Minnesota assures that the Basic State Grant funds allotted under Section 125 of the Developmental Disabilities Act of 1984 (P.L. 98-527) will be used to supplement and to increase the level of funds that would otherwise be made available for the purposes for which federal funds are provided and not to supplant such nonfederal funds (Section 122(b)(3)(D)) and that there will be reasonable state financial participation in the cost of carrying out the state plan (Section 122(b)(3)(E)).

TABLE 5.2

Summary of Proposed Developmental Disabilities Expenditures

State of Minnesota
FY Ending September 30, 1987
Federal DD Fiscal Year Allotment $811,163 (Anticipated)

Allocations to State Agencies by Sources of Funds (Projected)
Designated State Agency: State Planning Agency

NON FEDERAL FUNDS				FEDERAL	
State	Local	Non Profit	Total	FUNDS	TOTAL
$30,000.00	$274,686.00	$66,585.00	$371,271.00	$811,163.00	$1,182,434.00

Allocations to State Agencies by Purpose (Projected)
Designated State Agency: State Planning Agency

TYPE OF		PLANNING			PRIORITY SERVICE AREA	
FUNDS	TOTAL	Council	Other	ADMINISTRATION	Case Management	Employment Related
Federal	$ 811,163.00	$36,534.00	$211,300.00	$36,073.00	$487,256.00	$40,000.00
Non Federal	371,271.00	0.00	0.00	30,000.00	326,271.00	15,000.00
TOTAL	$1,182,434.00	$36,534.00	$211,300.00	$66,073.00	$813,527.00	$55,000.00

5.3
Application Procedures for Subgrantees

The current grant cycle began in June 1985 with the selection of priorities by the Governor's Planning Council on Developmental Disabilities. The Grant Review Committee met to prepare a Request for Proposal (RFP). Notice of the availability of the RFP was published in the December 20, 1985, Minnesota *State Register.* Notices were also mailed to each eligible applicant. The RFP solicited applications in four funding categories: (a) research, (b) improving efficiency of case managers, (c) empowering consumers, and (d) volunteer monitoring committees.

Applications were due by May 23, 1986. The Grant Review Committee members received copies of each application, along with a description of the evaluation process and a score sheet. On May 30, 1986, the Grant Review Committee met to discuss the grant applications and to develop recommendations for action by the full Council.

On June 4, 1986, the full Governor's Planning Council on Developmental Disabilities met to act on the Grant Review Committee recommendations.

In 1987 and 1988, the procedures will be similar.

SECTION 6:
Assurances

6.1
The state assures that each designated state agency will make such reports, in such form and containing such information, as the Secretary (of Health and Human Services) may from time to time reasonably require, and keep such records and afford such access thereto as the Secretary finds necessary to verify such reports. (Section 122)

6.2
The state assures that it will maintain such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursement of and accounting for funds paid to the state under Part 8 of Public Law 98-527. (Section 122(b)(1)(D))

6.3
The state assures that it will establish a method for the periodic evaluation of the plan's effectiveness in meeting the objectives set forth in the plan. (Section 122(b)(2)(E))

6.4
The state assures that funds paid to the state under Section 125 will be used to make a significant contribution toward strengthening services for persons with developmental disabilities in the various political subdivisions of the state. (Section 122(b)(3)(A))

6.5
The state assures that part of the funds (under Part B) will be made available to public or nonprofit private entities. (Section 122(b)(3)(B))

6.6
The state assures that funds paid to the state under Section 125 will be used to supplement and to increase the level of funds that would otherwise be made available for the purpose for which federal funds are provided and not to supplant such nonfederal funds. (Section 122(b)(3)(D))

6.7
The state assures that there will be reasonable state financial participation in the cost of carrying out the State Plan. (Section 122(b)(3)(E))

6.8
The state assures that services furnished, and the facilities in which they are furnished, under the plan for persons with developmental disabilities will be in accordance with standards prescribed by the Secretary in regulations. (Section 122(b)(5)(A)(i))

6.9
The state assures that buildings used in connection with the delivery of services assisted under the plan will meet standards adopted pursuant to the Architectural Barriers Act of 1986. (Section 122(b)(5)(A)(ii))

6.10
The state assures that services are provided in an individualized manner consistent with the requirements of Section 123 (relating to habilitation plans). (Section 122(b)(5)(B))

6.11
The state assures that the human rights of all persons with developmental disabilities who are receiving treatment, services, or habilitation under programs assisted under this title will be protected consistently with Section 110 (relating to the rights of persons with developmental disabilities). (Section 122(b)(5)(C))

6.12

The state assures that special financial and technical assistance shall be given to agencies or entities providing services for persons with developmental disabilities who are residents of geographical areas designated as urban or rural poverty areas. (Section 122(b)(4)(F))

6.13

The state assures that it has undertaken affirmative steps to assure the participation in programs under this title of individuals generally representative of the population of the state, with particular attention to the participation of members of minority groups. (Section 122(b)(5)(D))

6.14

The state assures that there has been provision for the maximum utilization of available community resources, including volunteers. (Section 122(b)(6)(A))

6.15

The state assures that the composition of the State Planning Council on Developmental Disabilities meets the requirements of Section 124. (Section 122(b)(1)(A))

6.16

The state assures that it will take affirmative action to employ and advance in employment qualified individuals with handicaps on the same terms and conditions required with respect to the employment of such individuals by the provisions of the Rehabilitation Act of 1973. (Section 109)

6.17

The state assures that not more than 25 percent of the formula funds will be made available to the State Planning Agency, the designated agency, for the provision of services by the State Planning Agency. (Section 122(b)(3)(C))

6.18

The state assures that this plan has been developed after consideration of the data collected by the Minnesota Department of Education under section 618(b)(3) of the Education of the Handicapped Act. (Section 122(4)(D))

6.19

The state assures that not less than 65 percent of the amount available to the state of Minnesota under Section 125 will be expended for service activities in the priority services. (Section 122(b)(4)(E)(ii))

6.20

The state assures that the state will spend less than 5 percent of the Basic State Grant monies for the administration of the plan. (Section 122(d)(1))

6.21

The state assures that at least 30 percent of the Basic State Grant monies will be used for service activities for persons with developmental disabilities and the planning, coordination, and administration of and advocacy for provision of such services. (Section 122(4)(E)(ii))

6.22

The state assures that additional information, as may be required by the Secretary of the Department of Health and Human Services, will be provided. (Section 122(7))

SECTION 7:
Attachments

Summary of Comments

Several categories of concerns emerged from testimony given at the twelve public meetings. The numbers following each topic indicate the frequency of people addressing a particular issue.

Alternative Living:

- Accessible housing — 46 including a petition signed by 39 families in Itasca County.
- Development of alternatives (guidelines, standards, models) — 6.
- Benefits of full array — 5.
- State-operated services — 3.
- Family support — 3.
- Training — 2.
- Respite care — 2.
- Other: geriatric, mentally ill, funding, termination of services — 1 each.

Case Management:

- Current problems (ratios, training, competence) — 12.
- Need for training, standards, models, evaluation — 12.
- Positive benefits of case management — 10.
- Family issues and monitoring — 5.

7.1
Public Forum — A Summary of Testimony

Introduction:

The Governor's Planning Council on Developmental Disabilities (GPCDD) sponsored a series of twelve public meetings throughout Minnesota in May and June 1985. The purpose of these meetings was to obtain testimonies from interested individuals, parents, providers, advocates, and government agency representatives regarding the four federal priority areas: (1) alternative community living services; (2) employment-related activities; (3) child development services; and (4) case management services. People were encouraged to focus their testimony upon one or more of these priorities.

Written testimony was also encouraged in the event that people could not attend the meetings held in their area.

Publicity:

The public meetings were widely publicized. An announcement and a schedule were published in the *State Register* on May 13, 1985.

Over 2,000 invitations and schedules were sent to selected individuals, agencies, and organizations. An announcement was also included in the monthly newsletter, *D.D. Information Exchange*. A news release was sent to over 450 contacts in the media such as newspapers, television, and radio stations. In addition, Council members were encouraged to promote the meetings that were scheduled in their particular areas of the state.

Sample of Testimony:

All statements made at the public hearings and written statements received in the mail were recorded and summarized in a report to the Governor's Planning Council on Developmental Disabilities. One general conclusion drawn from the statements was that all federal priorities seemed important.

Following are only a few examples of statements made by Minnesotans in relation to each priority area:

Alternative Community Living Arrangements:

- My son is physically handicapped and needs an accessible place with an attendant or aide. There isn't much available in this community.
- As foster parents for two and one-half years, we have not had any training available to us.
- Parents need support groups and education to be informed of what they can expect for their children with developmental disabilities.
- There is little planning and/or models of services for persons who are over 65 years old (residences, day programs, and sheltered workshops).
- Counties need more direction and help in setting up alternative living arrangements. Counties are being rushed without defined licensing procedures. Persons with disabilities are susceptible to abuse if providers aren't selected properly.

- Group homes are not necessarily the answer.
- There is a need for barrier-free housing, not necessarily Class B care.
- A full range of alternatives must be developed including foster homes, supervised apartments, behavior treatment, ICF/MR facilities, and respite care.
- There is no alternative living option for people with multiple handicaps in Itasca County. (Four different speakers addressed this issue.) A petition was received on June 28, 1986, which was signed by 39 families and staff requesting a group home in Itasca County.
- I am bewildered by all the talk and so little action in developing alternative living arrangements. People are unable to conceive of a new idea and put in place with no structure and no money. Developmental Disabilities funds can be used to offer providers upfront money for model programs.
- It is our (Union Representative) firm contention that federal funding could appropriately be spent on the development and implementation of state-operated community services facilities. The Department of Human Services' plan to establish pilot projects to demonstrate this alternative should be supported and implemented.
- There are still many people who are nonmentally retarded with physical handicaps who have been placed inappropriately in nursing homes. Hopefully, through the successful implementation of legislation relating to other related conditions, the needs of these people will be addressed.
- As more people who are severely/profoundly handicapped leave regional treatment centers, we must develop the means of developing alternative community living services *before* people are placed in such situations. Providers need training on this subject. We are fearful for the welfare of people with developmental disabilities who are forced, through rule changes, to leave the core of ICF/MR facilities without well-developed community services in place. Service development and placement should grow together.
- Some attention should be given to attendant care services, e.g., need for standards, training, and the quality of these services. Persons who are nonmentally retarded with physical handicaps could greatly benefit from these services.

Case Management:

- Current state policy requires case management services of a nature and type not previously implemented. Case management is a critical necessity, but we are placing the responsibility in untrained/unskilled hands. There are 87 counties, 87 philosophies, 87 concepts, 87 roles, and 87 responsibilities. The state needs to examine, plan, and implement a healthy system.
- The Lakeland Mental Health Center received a $7,000 (D.D./McKnight) grant and had a positive experience in providing case management in connection with the child development program. Case management ensures follow-up, case coordination, and enhanced communication to meet needs of children.
- Case management is a focal point of services to persons with disabilities until death do you part.
- Case management in itself is a 'systems approach' because the current delivery system still remains fragmented, inconsistent, and unreliable for consumers. Without competent and effective case management with a limited caseload, appropriate services are unobtainable, inadequate, inconsistent, and more importantly, the person's needs remain ignored.
- Olmsted County prepared a task force report on services and spent extensive time on case management. Case management is needed; there is need for one central point in order to minimize fragmentation.

Child Development:

- Family support – 12.
- Identification, intervention, nutrition – 11.
- Need for interagency cooperation – 4.
- Prevention campaign – 4.

Employment:

- Transition, coordination, cooperation among agencies – 16.
- Continue current grant program – 14.
- Positive benefits of employment – 6.
- Work with private employers – 5.
- Rural issues – 5.
- Training, epilepsy, follow-along, socialization, transportation, funding – 4 each.
- Organizational changes – 3.
- Mental illness – 2.

- Case management is the most encompassing priority and allows the widest array of services/needs that would fall under case management. Family support should be encouraged and is a high need in greater Minnesota.
- A system of case management would alleviate the problem of people "falling through the cracks" — people who don't really fit currently established programs. People get the most out of services when there is an advocate working with and for him/her.
- No more talk, let's get off our duffs. There can be 26 different agencies serving one family with 26 different goals in 26 different domains.
- Case managers are good people who are overworked and undertrained especially on state-of-the-art issues. Training isn't the answer; changing the staff-client ratios is. Currently, Ramsey County has an ideal of 1-50 clients, but Rule 185 calls for 1-23.7 clients or 81 hours per client per year. The only way to change case management is to hire more people.
- Good case management services are not provided and have led to inappropriate placements, poor monitoring, few innovative ISPs, and a waste of human and monetary resources.
- Case management is the weakest area of services and desperately needs attention.
- We have discovered many older people with disabilities living at home with elder parents. There seems to be no planning taking place for the event in which the parents die or until a crisis occurs. Much smoother transitions could take place if families can be guided to make realistic plans.
- Our county social service agency is seeing an increase and duplication of paperwork. Caseloads are too high and case workers often lack an in-depth knowledge of every persons' needs. The turnover among case workers is high, and there is always a need for providing in-service training.
- Grant funds should focus on development of training and development of several rural and urban case management demonstrations. Outcomes include awareness of the role of the case manager, positive administrative atmosphere, skills for development of ISPs, statewide normalization philosophy, stand-along training.
- The Council will have a more sweeping impact with case management. Other priorities are already underway. Leadership and direction are needed across the age span.

Child Development Services:

- Child development services would help a community focus on prevention, early identification, and intervention.
- There is a need to make a concerted effort to focus on the needs of young children with special needs and their families. Also, there is a tremendous amount of information on prevention which needs to be shared with the general public.
- In order to achieve a comprehensive service delivery system, Minnesota must now work to ensure that mechanisms exist to identify children and provide necessary follow-up services to the family and child. Project "Access" in New England and Iowa's regional system are two examples of a comprehensive approach.
- We know that people's fears toward people with handicaps are greatly reduced when they are provided the opportunity to interact directly with them. So many of these fears and prejudices can be avoided by mixing (mainstreaming) children (disabled with nondisabled) when they are young. It boils down to dollars and cents in the school system, serving children from birth to four.

- In Colorado, there is a three-phase program to address children's issues: (a) a collaborative agreement regarding early identification, (b) increasing public awareness, and (c) educating health professionals to work more effectively with families.
- Programs like Pilot Parents are an invaluable aid and should be funded.
- Over the past 24 years, many children have come to our schools and have shown that they would have benefited from earlier intervention.
- We need services to monitor the nutritional status of high risk children. Poor nutrition of children can result in irreversible handicaps.
- Forty percent of the clients of the Upper Mississippi Mental Health Center (UMMHC) are children. The UMMHC operates a level 5 day school as an alternative to residential treatment. This approach avoids out-of-home placement. There is a two-month waiting list.

7.2
Annotated Publication List of the Governor's Planning Council on Developmental Disabilities, State Planning Agency

7.2.1
Policy Analysis Series: Issues Related to Minnesota's State Hospitals[1]

Introduction

During the 1984 Legislative Session, the Minnesota Legislature mandated the establishment of an Institutional Care and Economic Impact Planning Board to study the feasibility of using state employees in the operation of community-based services and to consider the possible economic effects from consolidation, conversion, or closure of state hospitals (Minn. Stat., Chapter 654, Section 19). A policy was established that deinstitutionalization be carried out in a manner that ensured protection of the interests of employees and communities affected by deinstitutionalization of state hospitals. The Board consisted of commissioners of the departments of Human Services, Administration, Employee Relations, Health, Finance, Veterans Affairs, Corrections, Housing Finance Agency, Economic Security, and Energy and Economic Development, and the Director of the State Planning Agency. The Developmental Disabilities Program, Minnesota State Planning Agency, was given the responsibility for conducting the study and coordinating the plan.

As requested by the 1984 Legislature, the Institutional Care and Economic Impact Board submitted recommendations and findings to the Legislature on January 31, 1985. The report was contained in eight technical papers, *Policy Analysis Series: Issues Related to State Hospitals* and an abbreviated policy briefing publication, *Minnesota's State Hospitals: Mental Retardation, Mental Illness, and Chemical Dependency:*

Paper No. 1: Minnesota State Hospital Facilities and Alternative Use. (1985, January). The major focus of this study was an analysis of the general condition of state hospital buildings and potential alternative uses of those buildings. This report summarized information which would aid in determining future disposition, conversion, or consolidation decisions: (a) the physical condition ratings of buildings (i.e., age of buildings, property size, building square footage, physical condition, plumbing condition, and electrical condition); (b) cost considerations of renovations or demolition; (c) surplus property procedures and issues; and (d) the results of a national survey of alternative uses of vacated grounds and buildings.

[1]The Minnesota Legislature has changed the term "state hospital" to "regional treatment center."

Regarding the national survey, 43 state agencies reported that they did not save money by using state hospitals for other government uses rather than renting or building other facilities. This was due in large part to the condition and age of the buildings, energy costs, and renovation costs. Of the 31 institutions reported closed nationwide, none had been purchased by private industry. Over half had been converted to other types of government-operated institutions, e.g., corrections, Veteran's, geriatric apartments, college, and religious organizations. This report concluded that specific alternative use decisions will require the active involvement of state, county, and local agencies, and state hospital communities if the economic impact on the community is to be significantly reduced.

Paper No. 2: Minnesota State Hospital Energy Use and Cost. (1985, January). This study compared the use of energy, energy efficiency, and cost for each of the eight state hospitals for the years 1979 through 1983. Energy use during this five year span was marked by rapidly rising fuel prices and attempts to shift to lower price fuel sources. Energy conservation measures recommended in this report included: utilization of shared savings contracts; use of alternative fuels; purchase of electricity from wholesalers; separate metering of leased or rented buildings to the tenants; identification of surplus buildings for demolition to eliminate heating costs; and installation of improvements such as summer boilers.

Paper No. 3: A Profile of Minnesota State Hospital Employees. (1985, January). This study was directed toward the concern expressed by the Minnesota Legislature as to the effects on the employees should a state hospital close. The Legislature sought specific information about the employees: What is the projected displacement of state hospital employees because of deinstitutionalization, and what is the extent to which displacement can be mitigated through attrition, retirement, retraining, and transfer?

There were over 5,900 people, including part-time and intermittent employees working at the eight state hospitals. Over half of the employees were involved in direct care and were often female. The average wage of direct care personnel was $8.10 per hour, or about $5.00 above minimum wage. The length of service averaged over eight years, and the separation rate varied by location. An estimated 1,100 employees (18.5 percent) would be eligible for retirement during the next five years.

The State Planning Agency conducted a survey of state hospital employees to determine future career choices. Most of the 3,154 respondents indicated preference for public sector employment.

This report suggested that creative approaches be considered in making early retirement more attractive rather than incur layoff costs. The portability of pensions may also need to be investigated at the state level to encourage transfer of employees rather than layoffs.

Paper No. 4: The Economic Impact of Minnesota State Hospitals. (1985, January). This report analyzed the impact each state hospital has on the local economy. A large industry such as a state hospital contributes significantly to a community's economy. The smaller the community and less diverse its commercial or industrial base, the greater the impact of any closure or downsizing. Economic impact is not only a function of where employees live and spend their money but also where they work in terms of commuting distance.

Salaries of employees were the most significant factor in estimating community economic impact. The impact changes depended upon the dispersion of employees in a geographic area. Local purchases by the state hospital were a small percentage of local retail sales, due largely to a centralized procurement system.

State hospitals located in rural areas with high unemployment present the most difficulty in terms of developing alternative employment strategies. Retraining and voluntary transfers of employees should be considered as a preferred economic development approach.

Paper No. 5: Public Opinions about State Hospitals. (1985, January). This report summarized testimony received from nine town meetings, over 400 letters, and a toll-free call-in day. Citizens were encouraged to provide input regarding the future of state hospitals and

the delivery of services to persons with mental illness, mental retardation, and chemical dependency. Over 5,000 people attended the regional town meetings. Attendance ranged from 260 people at Anoka to 1,500 people at Brainerd. Over 80 separate organizations were represented, and 362 individuals made presentations. In addition, 202 people expressed their opinions and concerns by phone. Successful public participation was largely attributed to local planning committees which were organized in the eight areas of the state served by the state hospitals, plus one in the metropolitan area.

The overwhelming message of the town meetings, phone calls, and letters was to keep the state hospitals open. There was great fear expressed that people would be "dumped" into the community without support. Public opinions underscored basic criteria for quality programs: (a) provide adequate support for people who are the "most difficult to place"; (b) provide affordable and accessible services; (c) provide services that respond to the special needs of each individual; (d) provide opportunity for families to be involved; (e) provide a range of services in each area: (f) provide coordination, follow-up, and monitoring; (g) provide staff who are competent, caring, and trained. The study concluded that there was little doubt that any change in the state hospital system would have direct consequences on residents/patients, families, employees, and communities.

Paper No. 6: Residents/Patients in Minnesota State Hospitals. (1985, January). This study was focused on the residents with mental retardation and the patients with mental illness or chemical dependency. Residents with mental retardation and patients with mental illness were analyzed by functional skill levels. Total populations served by the state hospital system had decreased dramatically, from a peak of 16,355 in 1960 to an average daily population of 4,006 in fiscal year 1984. By category, the average daily population of the state hospitals in fiscal year 1984 was: 1,230 people with mental illness; 2,182 people with mental retardation; and 594 people with chemical dependency.

Residents/patients with mental illness ranged from the severest forms of illness (9 percent) to the least severe symptoms (12 percent). Residents/patients who experienced psychotic episodes, attempted suicide, and abuse of drugs comprised 26 percent of the state hospital population. Ninety percent (90%) of the residents with mental retardation in state hospitals were classified as being severely or profoundly mentally retarded. Generally, this population was highly dependent in several areas of functioning. Residents/patients with chemical dependency were typically young white males who were single, unemployed, had a high school degree or less, were alcohol dependent, and indigent.

The authors concluded that while there were many factors which would influence the future of state hospitals, the most important factor must be the individuals for whom the state hospital exist.

Paper No. 7: The Cost of Minnesota State Hospitals. (1985, January). This report contained an in-depth review of national literature comparing costs of institutional and community settings for people with mental retardation, the revenue and expenditures of the Minnesota state hospitals, a comparison of community and institutional expenditures during fiscal years 1977 through 1984, and a needs approach to cost estimation.

Fifteen years ago, throughout the country, the care provided in state hospitals was primarily custodial in nature, and the cost per day was extremely low. Costs increased during the 1970s due to improved staffing as a result of court cases and federal standards. In this same period, people with developmental disabilities were moving to the community. Costs continued to increase in the state hospitals because: (a) the fixed costs increased because of fewer residents; (b) remodeling and construction occurred across the United States to meet federal ICF/MR standards; (c) staffing increased or stayed level in order to reach ratios; (d) unionization of public employees led to higher salaries; (e) inflation had an impact; (f) the proportion of residents with severe/profound mental retardation increased as less people with handicaps left the state hospitals; and (g) indirect costs were added such as overhead and other state administrative costs in order to maximize federal financial participation.

In fiscal year 1984, the total operating expenditure for the entire state hospital system in Minnesota was $149,498,251. Staff salaries, which included employee benefits, represented the largest object classification at $128,433,135 or 85 percent of the total operating expenditure. The statewide average hospital operating cost of care for one resident/patient for one year amounted to $37,317. Reimbursements in fiscal year 1984 totaled $120,594,420 from all sources. The largest source was the federal share of Medical Assistance, $52,656,694 or 43.7 percent. The second largest source was the state's own share of Medical Assistance at $46,825,724 or 38.8 percent. County payments amounted to $6,362,510 or 5.3 percent.

The number of community group homes in Minnesota have increased dramatically. Since 1980 in Minnesota, expenditures for community services have exceeded state hospital services. In 1984, $130 million was designated for community services (excluding SSI/SSDI and special education) and $95 million was allocated for state hospital services.

This report documented the difficulties of cost comparisons and outlined the various reasons why average per diem rates between state hospitals and community facilities are incompatible: (a) costs vary by type of resident (age, level of independence, services needed, and staffing needed), e.g., services to children and to persons with severe handicaps are more costly; (b) per diems do not contain the same items; (c) no standard chart of accounts or cost accounting system exists for all community programs; (d) determination of costs vary among cost studies, e.g., reimbursable cost reporting, average per person costs, fixed and variable costs, units costs, and needs approach; and (e) geographic location, size of population served, staff ratios, and special certification.

Paper No. 8: Options and Recommendations for the Minnesota State Hospital System. (1985, January). This report presented several options and a final set of recommendations approved by the Institutional Care and Economic Impact Planning Board. Options considered in the report were:

- Maintain all state hospitals but reduce staff complement in the mental retardation units and increase staff complement in the mental illness units;
- Decentralize the state hospitals and begin state-operated, community-based services;
- Increase efficiency and introduce elements of competition in all state hospitals; and
- Closure of one or more state hospitals.

Analysis of each option took into consideration possible effects upon residents/patients and families, employees, costs, and economic impacts on communities.

Recommendations for the 1985 Legislature included:

- Downsizing of the mental retardation units should occur in the 1986-1987 biennium with emphasis on natural attrition of staff. Staff ratios should remain in compliance with the *Welsch* Consent Decree;
- State-operated community services should be developed and tested during the 1986-1987 biennium; and
- The efficiency of the current state hospital system should be improved by adding management systems outlined in the section on competition.

Minnesota's State Hospitals: Mental Retardation, Mental Illness, Chemical Dependency. (1985, January). This publication served as the executive summary to *Policy Analysis Series: Issues Related to State Hospitals, Policy Papers No. 1* through *7*. Changes over the last two decades were described in terms of reductions in number of people served by state hospitals, philosophy, and methods of treatment. Several tables and graphs presented data from the state hospital *Policy Analysis Series*. The authors noted that the system had reached a point where decisions were required regarding the types and levels of services offered for people with mental illness, mental retardation, and chemical dependency.

7.2.2
Policy Analysis Series: Issues Related to the *Welsch* Consent Decree

The *Welsch* Consent Decree was signed in the U.S. District Court in September 1980.[1] The Consent Decree required the state of Minnesota to reduce substantially the overall population of persons with mental retardation residing in state hospitals by 1987. Provisions of the Consent Decree also addressed the need for improvement of conditions in state hospitals and the development of community services for persons with mental retardation who were to be discharged from state hospitals. This *Policy Analysis Series* presents the findings resulting from various studies conducted by the Governor's Planning Council on Developmental Disabilities, Minnesota State Planning Agency. These studies focused on several of many issues surrounding the process of deinstitutionalization and the dynamics of systems change.

Policy Analysis Paper No. 1: Taxonomy of Issues Surrounding Implementation of the *Welsch* v. Noot Consent Decree. (1981, March 31). This paper outlined the planning issues and problems related to the implementation of the Consent Decree and the agency responsibilities for certain mandated activities. Four major activities were described: (a) planning at federal, state, and county governmental levels; (b) financing deinstitutionalization; (c) administration, licensing, regulating, and monitoring issues; and (d) planning at the individual level.

Policy Analysis Paper No. 2: The Size of Community Residential Facilities: Current Guidelines and Implications for Planning. (1981, April 10; revised 1981, August). This paper addressed the types of alternative community living arrangements which must be developed by counties within the context of the normalization principle. Twelve conflicting size guidelines were discussed. Review of literature suggested that size of residential facilities may be an important factor in determining the degree to which normalization has been achieved.

Policy Analysis Paper No. 3: Interagency Cooperation: The Underlying Concepts of Trust, Incentives, Barriers, and Forms of Linkage. (1981, April 14). This paper reviewed both the processes which facilitate and those which discourage interagency cooperation. Available research was summarized regarding the concepts of trust, the differences between cooperation and competition, and barriers to and incentives for cooperation. A variety of possible program linkage structures to facilitate interagency cooperation were presented such as exchanging information, identifying problems, and projects displaying varying degrees of system development. Concrete examples of commonly adopted program linkages were drawn from Project Share's *Dimensions of Services Integration*. Interagency cooperation was identified as being essential to the implementation of the Consent Decree.

Policy Analysis Paper No. 4: Cost Function Analysis of Minnesota Intermediate Care Facilities for Mentally Retarded (ICF-MR) Per Diems. (1981, September 1). Based on the results of a multiple regression analysis, this report suggested that eight variables were statistically significant determinants of per diem rates: (a) staff-to-resident ratio; (b) number of nonambulatory residents: (c) years of operation of residential facility; (d) average age of residents; (e) profit/nonprofit status of facility; (f) facility size; (g) family owned and operated facilities; and (h) licensed capacity. Data suggested that smaller residential facilities were not incompatible with cost considerations nor were they inconsistent with state policy and the objectives specified in the *Welsch* Consent Decree.

Policy Analysis Paper No. 5: Admissions/Readmissions to State Hospitals. (1981, August 31). Analysis of state hospital admission and readmission reports indicated that: (a) approximately 80 percent of the admissions from family homes were for parental relief and that had these services been available in the community, many of these short-term informal admissions might have been avoided; and (b) nearly 60 percent of the informal admissions (other than respite care) specifically mentioned a lack of appropriate community support services. Behavior-related problems were a primary reason for admissions in Minnesota.

This report also outlined some essential components for planning of community services such as: (a) building capacity within existing services, such as foster homes; (b) adopting a zero reject model; (c) developing a comprehensive array of community services, including age-appropriate day programs, respite care, and effective individual program plans; (d) providing adequate staffing and staff training; and (e) assuring that appropriate transition activities were in place in institutional programs which would foster the eventual assimilation of persons with developmental disabilities into community programs.

Policy Analysis Paper No. 6: The Financial Status of Minnesota Developmental Achievement Centers: 1980-1982. (1982, January 11). Data from all 108 developmental achievement centers were collected and analyzed such as: (a) revenue; (b) expenditures; (c) profit/loss; (d) program per diems; (e) transportation per diems; (f) capital assets; (g) building accessibility; (h) licensed capacity; and (i) daily attendance. The total expenditures reported during 1980 and 1981 were $22,702,498 and $25,996,001, respectively. The average daily attendance was 4,219 persons in 1980 and 4,429 persons in 1982.

Policy Analysis Paper No. 7: The Program Status of Minnesota Developmental Achievement Centers: 1980-1982. (1982, January 18). This study of all developmental achievement centers in Minnesota in 1981 focused on personnel and other management issues. Significant findings included: (a) there were 978 persons employed as teachers/instructors and 254 administrators (full-time equivalent); (b) over half of the personnel had at least a four-year college degrees; (c) the turnover rate of personnel was 20 percent; (d) the statewide average hourly wage was $7.06; and (e) there were 1,244 out-of-county clients being served by the 106 centers.

Policy Analysis Paper No. 8: The Client Status of Minnesota Developmental Achievement Centers: 1980-1982. (1982, January 26). This report summarized the general characteristics about clients served by the developmental achievement centers in Minnesota from 1980 through 1982. Highlights of this study included: (a) among the 5,150 persons enrolled, over half were between ages 21 and 50 years old, and over 1,200 were of preschool age; (b) while close to 14.0 percent of those enrolled were described as moderately mentally retarded, there were over 28.0 percent with severe mental retardation, and 10 percent with profound mental retardation; (c) almost half of the clients (45.8 percent) were living in their own natural or adoptive homes, and the remaining number lived in group homes (41.0 percent) or in semi-independent living arrangements (2.0 percent); (d) an estimated 454 clients were ready to move into work activity programs and another 240 were ready to move into a sheltered work setting; and (e) there was a waiting list of 499 persons for receiving services at 32 developmental achievement centers.

Policy Analysis Paper No. 9; Summary of Issues, Programs and Clients in Minnesota Developmental Achievement Centers: 1980-1982. (1982, February 10). This report summarized some of the implications associated with the survey reports in the *Policy Analysis Series Papers No. 6, 7,* and *8.* Problems identified were future staffing levels, support services, client movement, and cutbacks in programs or services. Problems which curtailed the movement of clients were limited community resources, unavailability of appropriate placements, and inadequate support services. Possible solutions to bottlenecks in the system were suggested such as planning, improved coordination between agencies, refocusing of financial resources, and creation of a viable case management system.

Policy Analysis Paper No. 10: Update to Policy Analysis Series No. 5: Admissions/Readmissions to State Hospitals, June 1, 1981 to December 31, 1981; The Behavior Problem Issue. (1982, April 9). This study added further verification to the premise that behavior problems were the major reasons for admissions and readmissions of persons with developmental disabilities to state hospitals. Another major reason for many admission and readmissions was for the provision of respite care services intended to provide relief to parents or other caregivers.

Policy Analysis Paper No. 11: Analysis of Minnesota Property Values of Community Intermediate Care Facilities for Mentally Retarded (ICF-MRs). (1982, July 1). This paper dealt with the reality of property values of homes in neighborhoods that contain a group home for persons who are developmentally disabled. Using assessed value as a measure, property values of homes in 14 neighborhoods that contain a group home were analyzed for the year preceding and the year following the establishment of the group home. Changes in property values in these 14 neighborhoods were then compared with changes in property values of homes in similar neighborhoods that did not contain a group home. The findings of this study were consistent with findings of similar research conducted in other parts of the United States: (a) changes in property values were not related to the presence of a group home, and (b) neither the number nor the timing of property transactions in a neighborhood could be related to the establishment of a group home in the neighborhood.

Policy Analysis Paper No. 12: Analysis of Nonformal Training for Personnel Working in the Field of Developmental Disabilities in Minnesota: 1981-1982: (1982, January 3). Based on interviews with 19 individuals from selected public and private agencies and organizations, this study documented the quantity and content of nonformal training events (such as conferences, workshops, and in-service training) that occurred in Minnesota over a two-year period. Some of the findings were: (a) people were generally motivated to continue their education throughout their adult lives; (b) while millions of dollars were invested in nonformal training activities, there were few tangible results such as improved work performance; (c) few training activities were based on a conceptual framework; they were not designed with regard to individual needs and competencies desired; (d) there was a need for improved coordination and collaboration among agencies; and (e) the strengths of the many existing training resources should be recognized and utilized when designing future comprehensive training systems.

Policy Analysis Paper No. 13: A Survey of Formal Training Programs in Developmental Disabilities in Postsecondary Schools in Minnesota and Adjacent States. (1983, January 3). This paper summarized the findings of a survey of institutions of higher learning in Minnesota and neighboring states. The majority (57 of 89, 64 percent) of educational institutions offered some coursework in developmental disabilities. However, most courses focused on growth and development of children with handicaps. Very little coursework addressed the needs of adults or the needs of persons with severe and profound mental retardation. Moreover, there were no courses that dealt with persons who were developmentally disabled but who were not mentally retarded. This study also documented that the distribution of educational resources was uneven. Metropolitan areas had significantly higher numbers of qualified staff working in community agencies. Future development should build upon the existing training facilities which are located in each region of the state.

Policy Analysis Paper No. 14: Training Needs as Perceived by Residential and Day Program Administrators and Staff. (1983, April 13). This paper summarized the findings of a survey of residential and day program managers and direct care staff who work in community facilities serving persons with developmental disabilities. Sample personnel policies, job descriptions, job applications, and performance review forms were also collected and analyzed. The sample documents revealed the need for training of managers. A statewide random sample of 312 direct care staff members indicated the need for preventing behavior problems, designing and developing behavior management programs, and current information on handicapping conditions.

Policy Analysis Paper No. 15: An Update to Policy Analysis Series No. 4: Cost Function Analysis of Minnesota Intermediate Care Facilities for Mentally Retarded (ICF-MR) Per Diems: 1980 (1983, March 14). This analysis used data from 1980 and was an update to the earlier cost-function analysis reported in *Policy Analysis Series Paper No. 4.* The study of costs was seen as important for several reasons: (a) the mandate under the *Welsch* Consent Decree to reduce the number of people with mental retardation living in state hospitals; (b) the continued increase in the number of community-based ICFs-MR; (c) the "double-funding" dilemma of maintaining both a state hospital system and a community-based system of services; and (d) the emergence of alternative, cost-efficient models of residential care such as specialized adult foster care, semi-independent living services, and family subsidy and support programs.

According to this study, most people living in community ICFs-MR resided in larger facilities. Although the largest facilities accounted for only 4.1 percent of the total number of facilities, they accounted for nearly 1 out of every 4 community ICFs-MR beds. A major portion (71.2 percent) of the total operating budgets in 1981 was related to personnel costs. In the regression analysis for facilities serving more than 12 people (ranging from 13 to 171 residents), the equation accounted for 89.1 percent of the variation in per diems. Most statistically significant among twenty variables analyzed were: behavior problems, consultant contracts, occupancy rate, direct care staff (full-time equivalent), and Class A/Class B licensure. The paper concluded that although cost factors were important, other factors must also be considered such as normalization principles, appropriateness of services, and the provisions of least restrictive environments.

Policy Analysis Paper No. 16: A Statewide Summary of Sheltered Employment Programs. (1983, April 19). This paper presented findings of a survey of 25 sheltered workshops throughout Minnesota during federal fiscal years 1980-1983. The components studied were vocational evaluation, work adjustment training, long-term sheltered work, skill training, work activity, and work. Data on fiscal and programmatic status of the workshops were collected and analyzed. Some of the findings were: (a) sheltered workshops were experiencing lengthy waiting lists for services (such as 807 persons in 1982); (b) there was an overall trend toward service reductions in 1982 because of lack of available work; (c) changes in average daily attendance varied according to the type of sheltered employment program; and (d) total revenues for 1982 increased 5.2 percent over 1981 to a total of $35,746,058.

Policy Analysis Paper No. 17: An Update to Policy Analysis Series No. 6 through 9: The Financial, Client, and Program Status of Minnesota Developmental Achievement Centers: 1982 (1983, March 28). This paper presented findings of the 1982 survey of 107 Developmental Achievement Centers (DACs) in Minnesota. Some of the major findings included: (a) the statewide total revenues for DACs increased 5.5 percent over 1981; (b) 31 percent of the centers reported operating deficits for 1982; (c) 44.5 percent of the DAC clients lived in natural or adoptive homes, 43.3 percent lived in community group homes; (d) 402 persons were on waiting lists at 28 of the centers; (e) 528 adults were reported to be ready for work placement but were unable to move to such placements because of lack of available work stations, reluctance on the part of parents or the clients, client characteristics, or lack of community support services.

Policy Analysis Paper No. 18: The Minnesota Family Subsidy Program: Its Effect on Families with a Developmentally Disabled Child. (1983, May 2). Beginning in 1976, this subsidy program has provided grants to families up to $250 per month per family to purchase support services. Priority has been given to families with children who have severe and multiple handicapping conditions. Findings of the study revealed: (a) 97 percent of the families responded that the program was of great help to them; (b) the subsidies helped families to keep their child at home rather than to seek placement in state or community residential facilities; (c) families were better able to function and cope (financially, socially, and psychologically); and (d) such services can be a cost-effective and a humane alternative to institutional care.

Policy Analysis Paper No. 19: An Update to Policy Analysis Series No. 4 and 15: Cost Function Analysis of Minnesota Intermediate Care Facilities for Mentally Retarded (ICFs-MR) Per Diems: 1981. (1983, August 15). This paper presented the findings of a study of Minnesota community-based ICF-MR per diem costs. The study used 1981 data from the departments of Health and Welfare to identify factors that could explain differences in per diem rates found among ICF-MR facilities. This study updated the work completed in *Policy Analysis Series Papers No. 4* and *15*. One-way analysis of the data found significant differences in per diems as a result of location, size of facility, staff-resident ratio, class of facility (A or B), years facility has been in operation, ages of residents, degree of disability of the residents, and level of dependency of the residents. Multiple regression techniques tended to support the one-way analyses. The research showed that the importance of certain variables changed from previous years; however, the policy issues raised in *Policy Analysis Series Paper No. 15* remained relevant.

Policy Analysis Paper No. 20: Respite Care: A Supportive and Preventive Service for Families. (1983, October 18). This paper summarized literature relating to respite care and identified available resources which Minnesota could draw upon when planning and implementing future support services to families. Respite care services were described as supportive to families and a means of forestalling out-of-home placement. In Minnesota, there had been an overreliance on the use of state hospital facilities by families seeking temporary relief because respite care services were not available in most communities. Several key elements were listed for developing respite care as an ongoing social service in Minnesota.

Policy Analysis Paper No. 21: Summary and Analysis of Minnesota Developmental Disabilities Respite Care Demonstration Projects (Federal Fiscal Years 1981-1983). (1983, October 24). This continuation of *Policy Analysis Series Paper No. 20* presented a summary and analysis of 16 respite care demonstration projects that were funded by the Minnesota Governor's Planning Council on Developmental Disabilities over a three-year period. Securing a stable funding base was seen as essential to establishing dependable respite care services in Minnesota.

Policy Analysis Paper No. 22: Improving the Quality of Life for People with Disabilities: Potential Uses of Technology. (1984, April). This paper summarized literature relating to the expanding utilization of technology for persons with developmental disabilities. Some major findings were: (a) modern technology can improve the quality of life for persons with disabilities in the areas of communication, mobility, independent living, education, and employment; (b) technology is difficult to obtain because of inadequate funding; (c) people who need technological aids should have access to adequate assessment, prescriptions, and follow-up services; and (d) a state policy agenda for use of technology by people with disabilities in Minnesota should be developed and implemented.

7.2.3
Briefing Books for Minnesota Policy Makers

Developmental Disabilities and Public Policy: A Review for Policy Makers. (1983, January). Written in cooperation with the Center for Educational Policy Studies, College of Education, University of Minnesota, this publication provided information about persons with developmental disabilities, about trends in community services, and about policy issues and alternatives for the 1980s. Support for the policy goal of normalization was recommended. Furthermore, the state should move toward a consumer-powered system which starts with the client's needs and strengths, identifies the resources needed, and evaluates the system according to the client's progress. Funds should be directed toward services rather than facilities, and clients would not be forced to move as they became more independent or as their needs changed.

Toward a Developmental Disabilities Policy Agenda: Assuring Futures of Quality. (1984, March). This publication stressed that people with disabilities should live, learn, work, and participate with other citizens who are nondisabled. Components identified as essential for achieving several goals included: (a) a statewide prevention and early intervention system; (b) services to support families; (c) special education which would prepare students for independent living; (d) community integration and opportunities for competitive employment; (e) an array of community residential alternatives which would be flexible and responsive to individual needs; and (f) access to technology which could improve the quality of life of persons with developmental disabilities.

Mandate for Action: Recommendations of the Governor's Mental Health Commission. (1986, February 3). The Governor's Commission on Mental Health was formed on June 14, 1985, by Governor Rudy Perpich. The Minnesota State Planning Agency was called upon to provide technical assistance and staff support to the Commission as its members looked at several aspects of mental illness and issues related to mental health services and policy. While some positive trends and exemplary services were highlighted, the Commission noted that the mental health "system" was, "to a significant extent, divided, inconsistent, uncoordinated, undirected, unaccountable, and without a unified direction." Vigorous case management, individual service planning, and uniform placement criteria were absent. Recommendations were organized according to three themes: making a commitment, organizing to meet the commitment, and ensuring that the commitment was met. Immediate steps included: (a) the adoption of a mission statement in state statute; (b) the extension of the Bill of Rights to outpatient mental health services in state statute; (c) the creation in state government of a visible, responsible, and committed focal point of administrative and professional leadership; and (d) the continuation of a Governor's Commission on Mental Health to monitor and advocate the implementation of the recommendations contained in the report.

7.2.4
Studies and Reports Related to Minnesota State Schools/Academies for Persons who are Blind and/or Deaf

The Impact of Closure of the Minnesota School for the Deaf and Minnesota Braille and Sight Saving School from the Perspectives of Students, Families, and Local Schools. (1985, February 8). On January 3, 1985, Governor Rudy Perpich made a preliminary recommendation to close the Minnesota School for the Deaf and Braille and Sight Saving School located in Faribault. By mid-February, after considerable response from legislators, parents, teachers, and students (including a demonstration in the Capitol Rotunda), the Governor withdrew his recommendation.

The analysis in this report consisted of: (a) a review of every student record; (b) a survey of students; (c) a survey of parents; and (d) a survey of home district special education directors. The surveys of students and families documented universal opposition to the proposed closure: Many families would have considered out-of-state residential schools in the event of closure. Local special education directors expressed concern about closure without following due process procedures. In the event of closure, the local directors preferred placement in the home districts followed by placement in another district. The residential schools in Faribault were described by the respondents in terms of educational quality, opportunity for socialization, involvement in extracurricular activities, and an environment conducive to total communication.

Summary of Reports Prepared for the Minnesota Legislature Regarding Academies for the Deaf and Blind. (1986, February 3). The 1985 Legislature passed legislation requiring the State Planning Agency to direct a study in cooperation with the departments of Administration, Education, Employee Relations, and Finance. The study topics included: (a) management organizational structure; (b) governance; (c) financing methods; (d) staff/student ratios; (e) student assessments; (f) admission and discharge (entrance and exit) criteria; and (g) individual education plans. This document summarized the results of several documents prepared to address these areas. The citations for these documents are as follows:

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